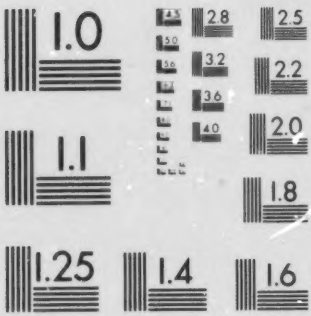

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ABSTRACT

This Congressional oversight hearing was convened to examine evidence that many of the nation's nursing homes restrict or deny access to the elderly poor and disabled, leaving the 18 million Americans dependent on Medicaid especially vulnerable to neglect and exploitation. Evidence was heard on discriminatory admissions, on the practice of demanding cash payments before accepting a Medicaid patient, on the eviction of residents once they become eligible for Medicaid, and on racial discrimination. Witnesses include a former nursing home admissions director, two citizens with experience of nursing home malpractice, an attorney from the National Senior Citizens Law Center, the attorney general of Maryland, and the deputy executive vice president of the American Health Care Association. Appendices, which make up almost 70% of the document, provide a summary of the committee findings; a survey of nursing home profits and Medicaid census; illegal and questionable clauses from nursing home admission agreements; case histories of nursing home discrimination victims; and supplementary materials from witnesses. (RDN)

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DISCRIMINATION AGAINST THE POOR AND DISABLED IN NURSING HOMES

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

SECOND SESSION

WASHINGTON, DC

OCTOBER 1, 1984

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DISCRIMINATION AGAINST POOR AND DISABLED IN NURSING HOMES

MONDAY, OCTOBER 1, 1984

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The committee met, pursuant to notice, at 9:35 a.m., in room 628, Dirksen Senate Office Building, Hon. John Heinz, chairman presiding.

Present: Senators Heinz, Glenn, and Burdick.

Also present: John C. Rother, staff director and chief counsel; Stephen R. McConnell, deputy staff director; Diane Lifsey, minority staff director; David Schulke, investigator; Isabelle Claxton, communications director; Robin L. Kropf, chief clerk; Kate Latta and Leslie Malone, staff assistants; James Salvie, investigative intern; and Gene Cummings, printing assistant.

OPENING STATEMENT BY SENATOR JOHN HEINZ, CHAIRMAN

Chairman HEINZ. Good morning. As the chairman of the U.S. Senate Special Committee on Aging, I have convened today's oversight hearing in light of incontrovertible evidence that many nursing homes in this country restrict or deny access to our Nation's most vulnerable citizens—the elderly poor and disabled.

Findings of a recent committee investigation show that in some areas of this country, up to 80 percent of what are called federally certified nursing homes are reported to actively discriminate against medicaid beneficiaries in their admission practices. These acts of discrimination are a flagrant violation of U.S. law.

The committee and I are deeply distressed by this evidence. We are equally distressed by the apparent glaring lack of enforcement of the law by both Federal and State governments.

The immediate victims of these illegal practices are the 18 million Americans who currently depend upon medicaid to pay for the health care they need. But virtually every apparently secure middle-income American is a potential victim, too. At a recent hearing before this committee, we learned that two-thirds of all middle-income patients in nursing homes spend their life savings within 2 years of admission and become medicaid patients.

The intent of the Congress in assuring medicaid beneficiaries equal access to care is clear. Back in 1977, we enacted legislation to make it a felony to solicit or receive funds from a medicaid patient as a condition of entering or remaining in a nursing home. Likewise, Congress sought to protect the disabled from discriminatory

admissions practices with its 1974 amendments to section 504 of the Rehabilitation Act.

But the committee's investigation into nursing home practices documents that nursing homes do demand cash payments before they will accept a medicaid patient. The family of a patient may be asked to sign a private pay contract, pledging to pay out-of-pocket for care already paid for by taxes and promised under Federal law. These contracts can stipulate fees of anywhere between $20,000 and $50,000 annually for up to 3 years.

The committee has also learned of instances where certified homes actually evicted residents once they spent down and became medicaid eligible, unless their children were willing and able to pay private rates. That many of these children are older Americans themselves, with after tax per capita incomes of less than $10,000 annually, makes this type of demand morally reprehensible as well as criminally illegal.

The committee's investigation revealed that illegal admission practices have grown like a cancer in the nursing home industry. Today, in my home State of Pennsylvania, in the Philadelphia area, for example, some 80 percent of providers are believed to have engaged in one or more of the practices that I have just outlined. Sixty-six percent of the homes in a county just outside Detroit demand cash payments before they will provide a bed and care for a medicaid patient. Recent estimates by a New Jersey task force say that 1,800 families are paying the private fee for a family member who is medicaid eligible. Each year, these families pay out $36 million for care that their taxes have already paid for.

In these States and others throughout the Nation, love and desperation are being grossly exploited by indifference and greed. But how did we arrive at this juncture, only 20 years after Congress proudly assured America's aged poor and disabled that they would receive adequate health care services, regardless of their income?

The answer is complex. Part of the problem is that States have attempted to minimize increases in their medicaid expenditures by slowing growth in the number of medicaid nursing home beds, even as the population needing them has continued to grow rapidly. These trends have created a seller's market in which nursing homes operate at 95 to 99 percent occupancy rates, and can afford to pick and choose the most profitable patients. In the seller's market, only the healthiest and the wealthiest are admitted for care.

A second reason for nursing home discrimination is avarice, greed. This seller's market is lucrative for nursing homes, so much so that in 1983, the California nursing home industry actually fought against a proposal that would have allowed the building of more facilities and nursing home beds.

We frequently hear that medicaid reimbursement rates are too low, and in some States, this is certainly the case. But we also know that investment analysts are recommending nursing home stocks because they promise as much as a 20- to 48-percent return on equity per year.

Meanwhile, the refusal by some nursing homes to accept medicaid patients contributes to higher health care costs for us all. Last year, the General Accounting Office reported that each year, medi-

care and medicaid pay a premium price for as many as 9 million patient days for patients backed up in hospital beds, while awaiting discharge to a nursing home, despite the availability of an adequate number of nursing home beds.

In discriminating against individuals with heavy or special care needs, nursing homes penalize the hospitals, who want to respond appropriately to our Government's new DRG, or prospective payment system, but are unable to place patients promptly in long-term care facilities. These barriers to admission may well undermine our health care reform efforts before they have a chance to succeed.

Losers in this equation are the most vulnerable members of our society. The refusal by nursing homes to care for the aged poor, and disabled, coupled with the powerful incentives that we have mandated for hospitals and the clear indifference of State and Federal Governments to the problem, threatens to confer upon our aged and disabled the status of boat people of the American health care system. We are here this morning to ensure that this Government does not cast them off and remain indifferent to their plight.

I would like at this time to welcome our first panel of witnesses and ask our first witness, Judy Moser, to please proceed with her testimony.

Ms. Moser, please proceed.

STATEMENT OF JUDY MOSER, MADISONVILLE, TN, FORMER NURSING HOME ADMISSIONS DIRECTOR AT A NURSING HOME IN TENNESSEE

Ms. MOSER. I was previously employed by a nursing home in Tennessee. I was the activity director, social service director, and director of admissions. I worked there a year and a half, and we had several management changeovers.

We had previously been managed by a nursing home chain, and I know that they were in it for the money, too, but they thought of the patient first, before the money.

On May 1, a new management company took over, and they constantly talked about how they were there for the money. Before this company took over, I had one waiting list, and I was told to go by the waiting list, and when a room came open, whoever was next on the list would get the room. When the new company took over, they immediately came in and talked to me about the admission procedures, and they told me to make two lists. one private pay and one medicaid. I said, "Can you do that? That is not legal. That is discriminating against them."

He said, "We can do it, and as a matter of fact, we are doing the State a favor by saving them tax dollars."

The nursing home was known to be a good place; we had a good nursing home, and we cared about people. You need to care if you work with old people.

These people constantly said, "You have too many feelings to work here," and they constantly talked about that they are here for the money; they are not here for the families or the patients or to be helpful to the community or the poor people. "We are here to make money."

It was a home. We made it a home, just another place for them to live and be happy, and not a place to come and die, where nobody loves you. When they took over, they started talking this away. They made the statement that they were going to keep the patients out of the front lobby. We had several patients that just refused to go anywhere else and sit. I told the new owner that this was their home, and they should be allowed to sit where they wanted to.

He said, "It is not a home. It is an institution and just a place for them to live."

I said, "As long as I am here, it will not be an institution, because it is their home." They were loved, and they knew they were, and they knew they were wanted there.

I just could not work there any longer and take their home away, because that is what the new company did, and because we had always done things by the rules, until they came—you know, people come to you, and they need a room, and you know they need a room. The families have to work, and these people have to have somebody to take care of them. They cannot stay at home alone. These people, unless they had money for private pay, the new owners would not let me admit them. You know, you have got somebody that you know needs to be there, and you know they do not have money, that they are poor, and they told me that we would not take anybody without private pay first, even an SSI patient who was already proven to be needy, even patients from other nursing homes who had already been approved, had approved PAE's, and we would have been reimbursed from day one. They had to come up with the money before we could admit them. I just could not tell people, "You cannot come here, even though you need a room." It really hurt me to quit, because it meant a lot to me. But I just could not be part of it.

The State, the rules and regulations are what is wrong. They are not stiff enough. These people have lawyers, and they know exactly what they can get by with. So the rules and regulations need to be stiffer, so people cannot make millionaires out of themselves through our old people.

What is needed in nursing homes is people who care. When you get a nursing home where people care, and you have a good staff, and the patients are happy, and then someone comes in and takes it all away—it is not right, and something needs to be done.

When I was filling some beds, and I had taken some medicaid patients who were already approved medicaid, one was from another nursing home and had an approved PAE, and I knew the rules, and I knew they would be approved from day one for our facility, so I was calling people on the waiting list, and evidently, someone on the waiting list knew it was against the law to charge private pay to an SSI patient, and they called the State in Nashville, the licensure board. That afternoon, the administrator came into my office and said, "The State just called me and jumped all over me for charging private pay to SSI patients. Who on that list would have called the State?"

I said, "I have no way of knowing." I had called about 10 families.

She said, "Well, we need to know who it is, because we cannot have anybody in here who would call the State."

After I quit, I called the State, because the owners were still doing that, and they were not reimbursing people. Poor people were going and borrowing money for this and may never get it back, you know, because they would never reimburse them. They said they were not supposed to reimburse people. So they did get on them again in Nashville. The licensure board was on them twice. But I do know that since I left, and since that has happened, they are still doing that, even though the State has been on them twice for it.

Chairman HEINZ. Ms. Moser, is there more that you would like to tell us on this?

Ms. MOSER. No; not right now.

Chairman HEINZ. I have some questions I would like to ask of you, but first, we want to hear from the other witnesses on the panel. I appreciate how difficult it has been for you to testify to this, because you have seen people, defenseless people, hurt, discriminated against, and you have tried to do what you not only thought was the right thing, morally, but also what was the legal thing. You tried to get the nursing home to not only be a good provider to the patients, but to be honest and law abiding, and obviously, it was very painful and frustrating and hurtful to you. It is hard to tell of one's pain and frustration and hurt, and we are appreciative.

I thank you.

[The prepared statement of Ms. Moser follows:]

PREPARED STATEMENT OF JODY MOSER

The following are incidents that occurred while I was employed as an admissions director and social worker at a nursing home in Tennessee.

The nursing home was previously managed by a company based in Alabama. On May 1, 1984, a new company assumed management of the home. We were the fifteenth facility in this organization.

Before this company took over we had a good, kind, and caring staff. We all made it one big happy family. A good place to live. We made it a vital part of the community, and made the patients feel happy, wanted, and very much loved. We were on TV three times because we were such a different kind of nursing home, the kind they all should be.

As I was in charge of admissions, I was approached by the regional administrator on May 4 about the waiting list. He asked me how many people on the list were private pay. Because we had previously made no difference in private pay and medicaid patients, I had no way of knowing this. He told me as of that day there would be two lists, one for private pay and one for medicaid. I asked him if this was legal, he said it was, and that as a matter of fact we were doing the "State" a favor by taking the private pay, for we were saving them tax dollars. I asked him, "If the discrimination board questioned me about this practice, was I supposed to show them both lists," and he replied, "Yes."

On May 10, I was called into the front office to talk with the regional administrator about the admissions policies. He told me we would not take anyone without private pay in advance. If they were medicaid or SSI they would pay until the first check was received from medicaid. I told him I did not think the State would approve of this practice since an SSI patient has already been proven needy by the State standards. He said this company is here to make money and that "all" patients "would" pay private in advance.

On July 9, I returned from my vacation to find there were four empty beds and I had to get them filled. I filled three of them with medicaid-approved people, and each had to pay private pay in advance. One of these even had an approved preadmission evaluation [PAE] from the facility in which they were transferring from, and would have been approved from day one for our facility. I had another inquiry

on the fourth and final bed that evening. The family wanted to transfer her to us from another nursing home in order to be closer to her. She had an approved PAE, was SSI only, and would have been approved from day one for our facility. The family asked to see me the next day. I told them before they came I would have to have private pay in advance, and asked, if they could handle that. they said they could, then asked if she was approved would they get any money back? I then proceeded to tell them that they would be reimbursed the entire amount ($812), when she was approved for our facility. They were relieved and said they would be in the next day.

At this time, I went into the office to tell the nursing home administrator that we were full again. She wanted a run down on the patients to be admitted. Everything was fine with her until I told her about the reimbursement. I had assumed that this new company would reimburse, since it had been the policy of the previous company and also a State regulation. I told her all of this. She stated, "We do not reimburse people." I said, "Let me get this straight, medicaid will pay from day one, plus we will have collected private pay for the same period, is that not double billing?" She saw immediately that I knew what I was talking about and that I saw what she was doing. She changed her tune on this. She said that we would hold off on sending in the PAE until the first of August, then we would not be double billing. I told her that was against State regulations also, she said it wasn't. She said by holding off on the PAE until August we could by rights collect the private pay without getting into trouble, besides we would have been making $5 per day more this way. I asked her, "Do you mean for a measley $100 more this month you would make a poor family have to probably borrow the money and never get it back, when we could help them save this money?" She said, "The families are not what's important here, we are here to make money." I replied, "Lady, I don't know how you can sleep at night, but I can't." I was very upset and left her office at this time.

On July 13, my friend Mrs. Bowers and I were still upset. We saw what the home was coming to. We both had the same opinion of what a nursing home should be. Through all other management changeovers we had been able to fight for the patients' rights and win, but we saw that with this company we could not win. We did not want to be a part of what the nursing home was to become. We were totally dedicated to making the patients as happy as we could. We went anytime day or night a patient needed us. We stood together through trouble and stuck by the patients. They felt secure through our working together for them. We talked at length about the new practices and decided to turn in our resignations because we could not support this discrimination.

We have continued to be supportive of the patients. We visit them on a regular basis to see about them.

I hope my testimony will help.

I will go all the way to help our old people; they deserve all the happiness and respect in the world.

Thank you very much.

Chairman HEINZ. Our second witness in the panel is Julie Green, who has come all the way from California to be with us.

Mrs. Green, would you please proceed?

STATEMENT OF JULIE GREEN, SEBASTOPOL, CA

Mrs. GREEN. In January, my mother had a massive stroke, and the doctors did not expect her to live. Well, of course my father had some savings, and we checked around and found what was supposed to be the best convalescent hospital in Fremont, CA. That is where my dad said we are going to put mother.

We had to sign a contract, stating that we would pay $1,600 a month for 1 year, and after that, if my mother lived that long—which no one expected her to—that they would take her as a medicaid patient; in California, it is called Medi-Cal.

Well, I started applying for Medi-Cal for my mother after the second month, because we could see that the finances just were not there. My father thought that he could maintain that, plus his own place to live. I applied, and it took me 3 months to get Medi-Cal. As soon as they found out at the convalescent hospital that mother

was authorized for Medi-Cal—I had not picked up the stickers, nothing—the administrator called me, a few minutes after 8 a.m. in the morning and said, "Get your mother out."

My mother could not speak. She had not been able to speak. She was completely paralyzed on her right side. She had virtually no use of her left hand, and she had no way of communicating.

I saw her not abused, but neglected. And to get to the point, we had to move my mother that day—not tomorrow or next week, but that very day. We had to get my mother out of there.

I told the administrator that I had to go to Hayward to pick up the Medi-Cal stickers for my mother. I said, "Please, do not bother her," because she did not understand. She had lost 85 percent of her mental capacity when she had the stroke. And I said, "Just leave her alone, please." He told me that he would. So, we went to get the stickers, and so forth. We came back to the convalescent hospital late in the afternoon. My mother's clothes were packed. She was tied in a wheelchair. Her bed was stripped. The mattress was rolled up—that day.

And before they would even admit my mother, we had to give them a check for $800, right up front, and after that, it was $1,600 a month. And mother stayed in there for 4 months and then went to another convalescent hospital that accepted Medi-Cal patients. She got, I would say probably the care was the same, if not maybe even a little bit better. The first administrator told me twice, on two different occasions, that he would like to be able to take Medi-Cal patients, but they just lost too much money. Now, this is a private family, from what I understand. They own approximately 12 convalescent hospitals in northern California, and they charge $1,600 a month, not including wheelchair use, medicine, feeder tube, catheter—it is just not right.

Chairman HEINZ. One question on your story, Mrs. Green. When you received word that they were moving your mother out, did I hear you correctly when you said that you and your family paid some money for her to be there for a while?

Mrs. GREEN. Oh, yes; we had paid $1,600 a month for 3 months up until that point.

Chairman HEINZ. And then, when they moved your mother out, at that point, you found another nursing home that very day?

Mrs. GREEN. They found it for us.

Chairman HEINZ. They found it. How did that nursing home compare to the home where she had been?

Mrs. GREEN. It was every bit as good.

Chairman HEINZ. And yet, one would take Medi-Cal and the other would not.

Mrs. GREEN. That is right.

Chairman HEINZ. All right, thank you. I will have some more questions for you.

[The prepared statement of Mrs. Green follows:]

PREPARED STATEMENT OF JULIE GREEN

My name is Julie Green and I live in Sonoma County, CA. My parents live in Fremont, CA. On or about January of 1984, my mother, Julia B. Rockett, had a massive stroke. This left her completely paralyzed on her right side and unable to speak. She also lost approximately 85 percent of her mental capacity. Mother stayed

in the hospital until the review board decided she was stable, at which point we were told she must be moved to a convalescent hospital at once. We admitted her to a convalescent hospital on January 30, 1984.

I began the process of applying for Medi-Cal. That took 3 months. I was told mother had been approved, after so much redtape, and to come back to the social service agency in Hayward the next day after 11 a.m. to pick up her stickers which they made retroactive to May. That's when the trouble started. On June 3, at approximetely 8:06 a.m., I got a call from the administrator of the convalescent home asking us to get mother out that day. He knew I was picking up the Medi-Cal stickers and he didn't want my mother to stay unless we continued to pay for her care ourselves. But we couldn't afford to do that. I asked him to please leave mother alone because she did not understand what was happening. After an exchange of words in which I was told that he was "running a business," Mr. Curry agreed to leave mother alone and I assured him he would get his money. When we arrived at the home that afternoon with the stickers, mother was in a wheelchair, her clothes were packed, her bed had been stripped and her mattress rolled up. I could not believe it. We then asked them if they would take the May Medi-Cal stickers and were told "No." Our private funds had run out and they wanted my mother out, period. The home is licensed to accept Medi-Cal but their policy is that they won't accept it until they have received $1,600 per month for 1 full year. This $1,600 does not include things like any medication, wheelchair use, laundry, etc.

Thank you for any and all help concerning this and some problems like this, some worse.

By the way, these things can and do happen to people of all ages, not just the elderly. It is just easier to mistreat them because they are so frightened to say or do anything. They know what can and does happen to anyone who complains about the care or lack of care. Things have to be changed.

Chairman HEINZ. Our third witness on the panel is Robert Snook, from Bayville, NY.

Mr. Snook.

STATEMENT OF ROBERT B. SNOOK, BAYVILLE, NY

Mr. SNOOK. Senator Heinz, my mother suffered a stroke on May 22, 1982, and was admitted to a hospital in Manhasset, NY, where she lived. The stroke left my mother paralyzed on her left side, and the course of her recovery was very slow.

The physician at first thought that the best chance for her recovery was to send her to a rehabilitation center, but none of the centers in our area would accept her. This required a quick course of action, because my mother had been in the hospital for approximately 6 weeks, and the hospital was interested in discharging her as rapidly as possible. And also, my mother was increasingly dissatisfied with the type of care she was receiving in the hospital, as it was not the type of care that could be provided at a skilled nursing home.

We were able to locate a suitable nursing home for her in Glen Cove, NY, and my mother was admitted to this nursing home on July 10, 1982. At the time of her admission, I signed an agreement which stated that she would remain a private-paying patient for a period of 18 months. At that time, I had no idea how long she would remain in the nursing home, or any knowledge of my mother and father's personal financial situation. The nursing home also informed me at the time she was admitted that my mother was not eligible for benefits under medicare.

When my mother was admitted, I paid for the first month of her stay, and shortly thereafter, a check for an additional 2 months, as a security deposit, was sent to the nursing home. Payment for the

next 2 months was made from my mother's personal savings account and money contributed by my brother and myself.

It became apparent that some other means would have to be found to finance her care at the nursing home, as her funds were being rapidly depleted. I explored the possibility of obtaining a reverse mortgage on my parents' house with one of the lending institutions in our area. When I discussed this matter with my parents' lawyer, he told me this was a bad idea, since my father was living in the house at the time, and the house was covered under the homestead provision of New York State law. He advised me to apply for medicaid for my mother.

I also discussed this matter with my own lawyer, who also advised against obtaining a reverse mortgage on my parents' home, and suggested that I contact a law firm he knew of that specialized in medicaid and medicare matters. I contacted this law firm, and they advised me to apply for medicaid immediately, and to make no additional payments to the nursing home.

On October 8, 1982, I made an application for medicaid for my parents with the Nassau County Department of Social Services. I supplied the department with all the material they requested and was told by the caseworker assigned to the case that my mother would be eligible.

Shortly after making the application for medicaid, I informed the business office of the nursing home that I had applied for medicaid for my mother. One day while visiting my mother, I was called into the business director's office, and he told me that I had signed a contract, and that he was going to hold me to the contract and sue me. But I continued applying for medicaid.

About 6 weeks after I had initially applied for medicaid for my parents, I received a notice that medicaid had been denied because I had signed an agreement with Glengariff Nursing Home to pay for private care for 18 months.

We requested a fair hearing on this denial. A fair hearing was held in the first part of February 1983. The administrative law judge ruled that the denial of medicaid was improper, and the Nassau County Department of Social Services was directed to provide medicaid retroactive to November 24, 1982.

Despite the ruling of the administrative law judge, it was not until June 1983 that the Nassau County Department of Social Services approved my mother's eligibility retroactive to November 24, 1982.

As I stated previously, I was being sued by Glengariff Corp. for failure to live up to the agreement I had signed at the time of my mother's admittance. On January 4 of this year, the suit was dismissed by the New York Supreme Court, because the judge found that the nursing home contract was unenforceable. I have since learned that Glengariff Corp. intends to file an appeal of this decision.

I might also state that my mother's denial of medicare benefits for the first 100 days of her stay in the nursing home was later appealed, and again, an administrative law judge ruled in her favor.

Chairman HEINZ. Mr. Snook, thank you very much. I will have some additional questions of you.

[Two letters to Mr. Snook from the Glengariff Corp. follow:]

THE GLENGARIFF CORPORATION

"A Nursing Home and Health Related Facility"

October 4, 1982

Mr. Robert Snook
25 7th Street
Bayville, New York 11709

Dear Mr. Snook:

We have been extremely patient in awaiting payment amounting to $2,915.87 since September 5, 1982 for the care of your mother, Margaret Snook, a inpatient in our Skilled Nursing Facility. We had sent three (3) payment reminder letters to you previously, dated 9/14, 9/20 & 9/24/82.

Accordingly, you are in default under the Sponsor's Agreement between The Glengariff Corporation and yourself dated July 10, 1982 in payment of the above charges. Unless the charges are paid by October 8, 1982, we will have no alternative but to discharge your mother from the Skilled Nursing Facility, return her to your custody and to collect the sums due Glengariff,from the security account.

I do hope the total payment will be forthcoming and that Mrs. Snook will remain here.

Sincerely,

THE GLENGARIFF CORPORATION
"A Nursing Home & Health Related Facility"

Kenneth Winston
Administrator

KW/nv

THE GLENGARIFF CORPORATION

"A Nursing Home and Health Related Facility"

October 13, 1982

Mr. Robert Snook
25 7th Street
Bayville, New York 11709

Dear Mr. Snook:

While we are appreciative of your efforts to make September payment for the care of your mother, Mrs. Margaret Snook, amounting to $1,831.49 on October 8, 1982 with the balance of $1,0R4.38 anticipated momentarily, we must now take measures to ensure future timely payments.

Specifically, failure to render October payment amounting to $3,006.15 by October 25, 1982, and failure to render future payments by the 5th of the appropriate month will compel us to initiate the following actions:

1. Request the discharge of your mother from our Skilled Nursing Facility.
2. To collect the sums due Glengariff from the security account.
3 To have a summons served to you pertaining to litigation for breach of the Sponsor's Agreement between us executed on July 10, 1982.

It is our sincere wish that future payments will be timely and that Mrs. Snook will remain an inpatient here.

Sincerely,

THE GLENGARIFF CORPORATION
"A Nursing Home & Health Related Facility"

Kenneth Winston
Administrator

KW/nv

Chairman HEINZ. Our fourth and last witness on the panel is Toby Edelman, staff attorney for the National Senior Citizens Law Center, here in Washington, and a member of the board of the National Citizens' Coalition for Nursing Home Reform.

Ms. Edelman.

STATEMENT OF TOBY S. EDELMAN, STAFF ATTORNEY, NATIONAL SENIOR CITIZENS LAW CENTER, WASHINGTON, DC

Ms. EDELMAN. Senator Heinz, thank you for the invitation to testify before the committee this morning. I will be submitting some additional testimony for the record.[1]

The witnesses before me this morning have told of their personal experiences with medicaid discrimination. And while these experiences are very disturbing to listen to, they are unfortunately not unusual. Anyone who has tried to find a nursing home bed for an elderly disabled person will have a similar story to tell.

If the prospective resident is a medicaid recipient, or if the person will soon run out of private funds and need to become a medicaid recipient, and especially if the person also needs a lot of care, chances are very slim that a bed can be found. Nursing homes prefer private-pay or self-pay residents, particularly those whose care needs are minimal. The reason is very simple. Since private-pay residents are more profitable for nursing homes, they are preferred.

I am talking this morning only about facilities that voluntarily participate in the medicaid program. With few exceptions, nursing homes have the choice of whether or not to participate in medicaid. But facilities that participate do so on their own terms, and that is the problem. With shortages of nursing home beds and high occupancy rates, nursing homes pick and choose residents who are most profitable for them.

Since I first wrote about the problem of nursing home discrimination against medicaid recipients almost 7 years ago, discussion of the issue, documentation of its existence, and State efforts to combat it have all increased. We at the law center and at the National Citizens' Coalition for Nursing Home Reform are hearing more and more about facility practices that discriminate against elderly poor people who desperately need nursing home care. With implementation of the DRG hospital reimbursement system, there are more medicare and private-pay residents looking for nursing home beds, and this decreases even further what is already extremely limited access for medicaid recipients and other poor people.

Many facility practices I will describe force families to pay for care that they cannot afford and that they are not legally obligated to pay. When prospective residents have no families, they may be denied admission and deprived of nursing home care entirely.

The discriminatory practices are varied. Many medicaid nursing homes claim they have no bed when an inquiry is made for a medicaid recipient. Sometimes, nursing homes offer to put the applicant's name on a waiting list. The waiting list may not exist at all,

[1] See appendix 1.

or it may simply be thrown into the trash can at the end of the month. People usually never hear again from the facility.

Sometimes, facilities ask for contributions to a building fund before they will admit a medicaid recipient. Or, as the previous witnesses have testified, facilities will require people to sign private-pay contracts, which obligate them to pay personally for their care for specified periods of time, chosen unilaterally by the facility, before they will be permitted to apply for the public benefit they are entitled to. People are forced to choose between a nursing home bed that they need and their legal entitlement to a Government benefit.

Facilities engage in other discriminatory practices as well, by manipulating their contracts with State medicaid agencies. They may sign provider agreements with the State agency that limit the number of medicaid beds they have, so that, for example, a 100-bed facility may have only 10 medicaid-certified beds. Or they may certify for medicaid only one floor or wing, rather than the entire facility. Both of these practices limit the number of beds that are even theoretically available for medicaid recipients.

Discriminatory practices such as these occur throughout the country. In fiscal year 1982, the State nursing home ombudsman program, funded under the Older Americans Act, identified discrimination against medicaid recipients as a very significant problem, cited by 20 States and the District of Columbia. More recent State reports underscore instances of specific discriminatory practices. For example, the New Jersey Nursing Home Task Force, in its report last summer, conservatively estimated that 16 percent of the State's private-pay residents were eligible for medicaid, but remained private-pay because they had signed private-pay contracts. The 16 percent represented 1,800 people out of 11,400 private-pay residents in the State. People were being asked to spend up to $2,000 a month for periods up to 3 years. These are people who were eligible at that time for medicaid.

Private-pay duration of stay contracts are so common and so serious a problem that they have been explicitly prohibited by State agencies now in Maryland, Virginia, New York, and Washington. Similar prohibitions are under consideration in Michigan and New Jersey.

What can be done? I think there are two things that we need to do. No. 1 is to enforce current laws that exist; and No. 2, we need to enact some additional protections.

There are some remedies to discrimination that exist, but these remedies need to be more widely publicized and aggressively enforced. As Senator Heinz said, it is now a felony under Federal law for a provider to charge, solicit, accept, or receive a gift, money, donation, or other consideration as a condition of admission or of continued stay. Many of the practices I described at the beginning of my testimony, such as private-pay contracts, are probable violations of this fraud and abuse amendment. U.S. attorneys and the Inspector General must investigate complaints in these areas and must prosecute violations of this law that we know occur.

The Office for Civil Rights in the Department of Health and Human Services should enforce the Federal law that prohibits discrimination against handicapped people.

The Department of Health and Human Services must also inform State agencies and the regional offices in the medicaid program of its interpretation that current Federal law prohibits limited bed provider agreements and should make sure that no State agencies use these contracts.

While enforcement of current remedies such as these would help alleviate discrimination against medicaid recipients to some extent, there is a need for additional legislation to require that nursing homes provide care to medicaid recipients without regard to their source of payment. We simply cannot allow facilities to continue using medicaid for their own purposes and on their own terms. Being a medicaid provider must obligate each medicaid facility to provide care to the poor, elderly, and disabled people who need its services. We need legislation that first, will clearly spell out the obligation of facilities to provide care to medicaid recipients; second, we need mechanisms to monitor facilities' compliance with the obligations we create; and third, we need strong public and private methods of enforcing the obligations we enact.

Thank you very much.

Chairman HEINZ. Ms. Edelman, thank you very much.

Before we begin questioning of our panel, I would like to turn, using our early bird rule, to my two colleagues who have joined us, for any opening statement they wish to make.

Senator Burdick, do you have any opening statement you wish to make?

Senator BURDICK. Thank you, no, Mr. Chairman.

Chairman HEINZ. Senator Glenn?

Senator GLENN. I have a statement, Mr. Chairman, but I would like to have it entered in the record, so we can get on with the questions.

Chairman HEINZ. Without objection, so ordered.

[The statement of Senator Glenn follows:]

STATEMENT OF SENATOR JOHN GLENN

Mr. Chairman, I regret that today's hearing is necessary. The decision to put an elderly family member into a nursing home is a difficult one even when it is clearly the most appropriate long-term care alternative. Now we learn that many elderly and disabled persons and their families are facing additional financial and emotional burdens in attempting to obtain nursing home care. They are being discriminated against by nursing homes that illegally require private payments to ensure the admission or retention of Medicaid-eligible patients. Families often feel guilty about putting elderly members in nursing homes. They should not be burdened by concerns about the quality of care their loved ones will receive, or whether that care will be terminated, unless they meet illegal demands for payments or "voluntary" donations.

The discriminatory practices in federally-certified facilities that have been uncovered by the Senate Aging Committee's investigation include:

Refusal to admit some or all Medicaid patients into vacant, certified beds.

Requirements for cash donations or payments over time as a condition of admission.

Eviction of residents who "spend down" and become Medicaid eligible; and

Refusal to admit patients with more severe medical conditions and disabilities.

I am concerned that although these practices are prohibited by Federal laws—section 1909(d) of the Social Security Act makes it a felony for a nursing home to solicit or recieve funds from a Medicaid beneficiary as a condition of admission or retention, and section 504 of the Rehabilitation Act of 1973 protects handicapped persons from discriminatory admissions practices—only a few cases have ever been prosecuted.

This hearing will serve an important purpose if we increase public awareness of the rights of nursing home patients, and determine workable ways to improve enforcement efforts. I do not understand why the administration declined to testify today. It is important for us to know why the Department of Health and Human Services has not used the power it has to discourage illegal discrimination practices, and it would be helpful to hear from them if additional enforcement power is needed.

As you, Mr. Chairman, and I, and the other members of the Aging Committee are well aware, our population is aging. And, the segment that is increasing most rapidly is the over-85-year-old-group—those most likely to suffer from chronic illness and need long-term care services. At the same time, Medicaid, which pays 90 percent of the public bill for nursing home care, is becoming a burden for State budgets. Many States are attempting to control Medicaid expenditures by enacting moratoriums on the construction of nursing home beds and limiting reimbursement rates.

These actions are causing access problems for patients needing nursing home care, many of whom are "backed up" in hospitals unnecessarily increasing Medicare expenditures. And it is likely that these problems will increase as Medicare's prospective payment system is fully implemented. Efforts to limit hospital patients lengths of stay will result in the discharge of patients requiring "heavier," more expensive care in nursing homes.

If the Medicaid payment rates set by the States are too low, this issue must be addressed. However, the answer must not be discrimination against Medicaid patients. Providers can challenge State payment rates in court if they believe they are inadequate. I look forward to hearing testimony about the State reimbursement rates and whether they are being challenged in court by providers attempting to provide high-quality care to all nursing home residents.

The area of long-term care is a priority issue for members of this committee. Today's hearing is one in a series on long-term care issues, including nursing home regulations, home health care, life care communities, and long-term care insurance. I am sure that other hearings will follow, particularly given the growing demand for long-term care services caused by our growing elderly population; the efforts of States to control their Medicaid expenditures; Medicare's prospective payment system for hospital stays; and the lack of a comprehensive, coordinated system of home- and community-based care.

I appreciate the participation of today's witnesses. Their testimony should help heighten public awareness of the rights of nursing home residents, and determine what actions are needed to fulfill the congressional mandate that all Medicaid beneficiaries have access to services equivalent in quality, amount, scope, and duration to that available to other patients.

Chairman HEINZ. Ms. Moser, again, I appreciate how difficult it has been for you to tell us of your experience at the nursing home that you worked in in Tennessee. You resigned your position there over differences with the nursing home. What did you tell the management there when you quit?

Ms. MOSER. I told them that this was the people's home, and that I would not be a part of making it an institution, and that I could not turn the poor people away when they needed to be there.

Chairman HEINZ. Now, you cited how the new administration of this nursing home made two lists, one for private-pay people, and another for medicaid people, and basically, took people from the private-pay list and did not take people from the medicaid list.

Did the new operator of the nursing home start to discriminate against heavy care patients, too, those who might be a bit sicker?

Ms. MOSER. Well, when the company took over, the staffing was 1 to 10, 1 aide to 10 patients. And when they took over, there were some aides who quit, and then, the day before I turned in my resignation, after some quit, we had staffing of 1 aide to 13 patients. And you just cannot give the good care if you have 13 patients. And all the good aides starting quitting, because they could not provide the care that was needed; they did not have time. And the day before I turned in my resignation—this was the main thing

that caused me to turn it in—they called a staff meeting and said they knew how to make money, that they were in it for the money, and that in order to make money, they would have to cut the staffing, so they were going to cut it again, and the care was going to go down even worse.

Chairman HEINZ. And was there any intimation to you, as part of the admissions process, that you should not admit sicker patients?

Ms. MOSER. Well, since the staffing was going to be less, we could not take heavier-care patients, unless they were private pay. If they were private pay, it did not matter.

Chairman HEINZ. I see. So again, the cutback in staffing put even more pressure to take private-pay patients and turn medicaid patients away.

Ms. MOSER. Yes, yes.

Chairman HEINZ. I understand that since submitting your resignation, that you are still unemployed. Do you have any regrets about your decision?

Ms. MOSER. I regret not being there for them and being able to help them, but no, I do not regret quitting. I did not want to become a part of what it is now.

Chairman HEINZ. Can you see any real business- or service-related reasons for that nursing to have discriminated and begin discriminating against medicaid patients?

Ms. MOSER. The only people the discrimination against the poor people helps is the management company. If it is a medicaid nursing home, and medicaid has approved it, then it should be for medicaid patients. The private pay people can afford to get somebody to come in and take care of their family member, but the poor people cannot.

Chairman HEINZ. And in this State, this nursing home said that it accepted medicaid patients; it chose to participate in the medicaid program, did it not?

Ms. MOSER. Yes, it did.

Chairman HEINZ. But yet, it decided that it would only choose to honor its legal obligations selectively, if at all.

Ms. MOSER. Well, they took medicaid when we could not fill a bed with private pay.

Chairman HEINZ. One other question. You mentioned the cutback in staffing, as well as the practices. Did the State health department inspection team—which I imagine visited periodically—was it effective in any way in enforcing the patients' rights? Are you in a position to answer that?

Ms. MOSER. Because of the rules and regulations, there is just really no way, it seems like, that they can do anything. They can keep coming back and getting on them and getting on them. But you just cannot shut down the nursing homes; they are needed. So you have got to somehow get to the rules and regulations, which are the culprit.

Chairman HEINZ. One last question, before my time expires, to Mrs. Green.

Mrs. Green, first of all, I understand that your mother, for whom you obviously had great affection, has since passed away, and the committee and I extend to you our deepest sympathy on that. We

appreciate, again, for you the difficulty of talking about a loved one and explaining to us how so many loved ones can become vulnerable to what are, frankly, extortionate practices.

Let me ask you just this question. Do you think the experience of your mother having to be moved out on literally 24 hours' notice, out of one nursing home to another, had any effect on her physical well-being?

Mrs. GREEN. Yes, I do.

Chairman HEINZ. Could you describe that for us?

Mrs. GREEN. Mother responded a little bit, because she was receiving therapy—not what she was supposed to have, but nonetheless, she was receiving some therapy. And there were times when I would go in and see my mother, and she would recognize me, and I could ask her a direct question and she would shake her head "yes" or "no." But you had to watch very, very carefully, or you would miss it.

When they moved mother, there was no therapy. However, they did get her up more, and put her in a wheelchair, so that she did not have pneumonia like she had at the first one, and after that, mother rarely recognized me. There were very few times that I would go in that my mother recognized me.

Chairman HEINZ. So, for some reason, her condition deteriorated quite noticeably after the move?

Mrs. GREEN. Most definitely.

Chairman HEINZ. It is a well-known phenomenon that when nursing homes have been shut down, ones that provide terrible care—and it is very difficult ever to shut a nursing home down, but we have had one or two instances where they have been so bad that they have actually been forced to close them in my home State of Pennsylvania—that when they are moved from a terrible nursing home to a decent nursing home, substantial numbers of patients have medical setbacks, and even die, as a result of the experience in simply being moved.

So I am not, frankly, surprised that your mother suffered some kind of a setback.

My time has expired, and I would like to call on Senator Burdick.

Senator BURDICK. Thank you all for your testimony this morning. I would like to address my questions in the time I have to Toby Edelman.

On page 4 of your statement, you ask the question:

> What can be done about discrimination against medicaid recipients? Two things: Enforce current laws and enact additional protections.

On page 5, you say,

> While enforcement of current remedies such as these would help alleviate discrimination against Medicaid recipients to some extent, there is a need for additional legislation to require that nursing homes provide care to Medicaid recipients without regard to their source of payment.

Would you like to elaborate on that?

Ms. EDELMAN. About what I mean by that remedy?

Senator BURDICK. About what type of legislation you would like to have enacted.

Ms. EDELMAN. Because of the absence of assistance from the Federal law, a number of States have tried to enact various kinds of remedies to require nursing homes to provide care to people without regard to source of payment. And some of the States will say, for example, that applicants for care have to be admitted on a first come, first served basis, that the source of payment just cannot be the factor and facilities just cannot do that. That is the law in Connecticut.

Other States are doing other kinds of things in order to try and eliminate this kind of discrimination. Minnesota has a law that was enacted in 1976 that says if a nursing home is in the medicaid program, it cannot charge private-pay residents any more than the medicaid rate. It is a rate equalization law. Facilities presumably should be getting the same rate for everybody, so that the private-pay people are not subsidizing the medicaid program, and medicaid is not subsidizing private pay. The theory, or at least one of the theories, behind Minnesota's law, is that there would not be discrimination because facilities would get the same no matter who was provided care.

There are a variety of different approaches that States are taking, and I think Congress needs to look at these fairly carefully, and figure out which approaches should be enacted at the Federal level.

Senator BURDICK. Well, you say, "There is a need for additional legislation to require that nursing homes provide care to medicaid recipients without regard to source of payment." Suppose there is no source of payment? How do you take care of that? What happens to that patient?

Ms. EDELMAN. Do you mean people who are not eligible for medicaid under their State programs?

Senator BURDICK. Yes, or for some reason, they are not getting their medicaid payments, or they have lost eligibility. What is the alternative?

Ms. EDELMAN. Well, there are some nonprofit facilities that received Hill-Burton assistance that have a requirement of uncompensated care. They are required under the Hill-Burton law and regulations to provide care for people who have no other source of payment; they have to provide care for free.

There is a problem with the medicaid program that a lot of people who are poor and cannot afford to pay for their care are ineligible. That is a problem with the medicaid program. There are some difficulties in the way States have enacted that. But for this issue, we want facilities that have agreed to accept medicaid to take medicaid recipients.

Senator BURDICK. Well, I am with you completely on this, but I am just wondering how you can compel an institution to keep on paying if there are no funds coming in.

Ms. EDELMAN. In this statement, I am not talking about the people who are not eligible for medicaid. I am just speaking here about the discrimination against medicaid recipients by nursing homes that are choosing to be in medicaid. The problem that I see is that nursing homes are in medicaid, and then they still do not take medicaid recipients. Either they only allow people who are private pay, and use up their money after 2 or 3 years to go on

medicaid, or they just do not take medicaid recipients at all. They just have those beds for whatever purpose they want, and whenever they want to use it. And that is what I think is the problem.

I think what you are talking about is a separate problem, and it is a very serious problem, I agree with you—people who have no source of health care—medicare will not pay; they are not eligible for medicaid; there is no private insurance—that is a serious problem. But I do not think we can deal with that in this particular situation.

Senator BURDICK. What you are saying, then, in effect, is that they are not evenhanded about paying and nonpaying patients; is that correct?

Ms. EDELMAN. Nursing homes are not evenhanded about accepting medicaid recipients, or people who do already qualify for the medicaid program.

Senator BURDICK. Thank you very much.

Chairman HEINZ. Senator Glenn.

Senator GLENN. Thank you, Mr. Chairman.

We do appreciate very much all of you being here to help illuminate some of these problems. One of the areas I would like to ask a question or two about is what would it have taken in your cases to have taken care of those who were being admitted to the nursing homes at home? What kind of additional help would you have needed? We have looked into that some as a committee in the past, as to whether there are not a lot of people being admitted to nursing homes that, if we had some respite care or help or some sort of aide in the home, it would be far less costly and yet would give them care in their own surroundings, in their homes, where they have been accustomed to living.

Would that have helped in your cases? I guess I would start with you, Judy, if you would, please. You have seen a lot of these people coming in. Is that a factor that we should explore further, so that there is, perhaps, not the great numbers of people trying to get into nursing homes and not being able to get in. If we had a better home health care type system, would that be good?

Ms. MOSER. Yes, Senator, that would be good. This lady was talking to me about starting a residential home, turning her home into a place for the elderly. And we started checking in on it, and we even had the licensure board down. But the problem with that would be that these people do not make enough money, the medicaid patients. Maybe they just draw $159 a month, and you could not even take care of somebody, even in a residential home, for $159 a month. There is just not enough funds.

In order to start a residential home—and we looked into it real well—you would have to charge private pay. You could not take a medicaid patient, because you could not manage on $149 a month to take care of someone, and feed them right.

Senator GLENN. Well, Senator Burdick was questioning along the line of what do they need to run a home, and so on. I do not have figures on that, but it would seem to me that if we could provide some home care in these situations, it would be less costly and perhaps better for the people, better for the elderly involved, than them going off to a home.

Mrs. Green, could you have coped had you had more help at home?

Mrs. GREEN. No. There was no way. My mother required 24-hour care. I am not trained to change a catheter. My mother had a feeder tube down in her stomach. My mother could not help do anything. She was paralyzed. And also, she could not speak, so she could not tell us what she needed or what she wanted.

We looked into the home thing, and you can get a volunteer or a nurse's aide who would come in for 2 or 3 hours, twice a week. But then, what happens to the rest of the day and night? My father wanted to try to bring my mother home, but he had heart surgery 6 years ago, and he has congestive heart failure now, and there is no way my father could have done it. I could not even lift my mother, although she only weighed 55 pounds at the time.

Senator GLENN. Did you say 55 pounds?

Mrs. GREEN. Yes; 55 pounds.

Senator GLENN. Mr. Snook.

Mr. SNOOK. In my mother's case, I would say that home care was not practical. There are several problems with home care, if I may take a minute or so. One is that my mother is confined to a wheelchair, and in her home, the bathroom facilities are located on the second floor. This is one of the problems, that if somebody is going to receive home care, there has to be some provisions in the law to provide toilet facilities on the ground floor or an easy means of their getting to such facilities.

My father, who also required nursing home facilities, did have some experience with home care. But his experience, in my opinion, was not satisfactory. There is no question in my mind that it is the least costly method and probably the most satisfactory method for our elderly citizens, because most of them would prefer to remain in their homes. But the problem is that the help that is available for these people is inadequate. My father had problems getting a cleaning lady and somebody to come in and cook for him. What often happens in these cases is that there is a lapse in care, and then a family member will have to take over care for 2 or 3 days.

I believe that the home-care program has many shortcomings, but I think it might be well to look into strengthening this program in the future.

Senator GLENN. Thank you very much.

Ms. Edelman—I know my time is up, but if we could just have another minute, Mr. Chairman.

Ms. EDELMAN. I certainly agree that there are some people who probably would be able to remain at home with additional services. But as we are hearing, many nursing home residents are very, very disabled, and families are simply unable to provide the care.

That is what the GAO study found last summer, that nursing home residents are becoming more and more disabled. People are putting family members in nursing homes because they cannot provide the care themselves, even with home care.

Senator GLENN. Yes; I think it is obvious from the experiences that you have had here, where these are extreme cases, they were nursing home cases. What we have looked into a little bit in the past is perhaps where there are marginal cases where people could

be cared for at home, had they been given a little more help from somebody—one of the social services organizations in the community, or Federal help, or something that would be short of being put into a nursing home full time.

Thank you all very much. My time has expired.

Chairman HEINZ. Senator Glenn, thank you.

On Senator Glenn's point—it is a well-taken point—it is a fact that the so-called 2176 waivers, the home- and community-based care waivers, which have been implemented in several States, Oregon, for example, have indeed reduced the institutionalization, we understand from initial data, of medicaid and other patients, these being medicaid-directed waivers for community-based care.

However, these waivers are likely to expire soon, indeed they do expire soon, unless extended by the Office of Management and Budget, and unless they are extended—and present indications are that OMB does not intend to extend them—we will have a collapse of these waiver programs which, frankly, demonstrate that there is a very good, cost-effective rationale for home- and community-based care.

So I hope the members not only of the committee, but our colleagues in the Senate, take note on that.

I have a question for Mr. Snook, who had a remarkable experience in that his family was essentially sued by the nursing home.

Could you tell us, Mr. Snook, why the judge dismissed the case against you? Can you tell us why she decided you did not have to make up the difference?

Mr. SNOOK. Well, essentially, the judge ruled that it was against medicaid policy and also against public policy as established by Congress.

Chairman HEINZ. Now, as I understand it, it was signing the agreement that really caused problems for you. I think I am probably right in saying that your mother was denied medicaid although she had money, because you signed that agreement to pay for private care for your mother for 18 months. Is that right?

Mr. SNOOK. That is correct.

Chairman HEINZ. Your mother, as you said, was not a candidate for home care. She was unhappy in the hospital. You tried to accommodate her by moving her into a nice nursing home.

Given the experience that you have been through, where you were given a piece of paper to sign, you thought your mother was going to be properly taken care of—obviously, that was not quite what the nursing home had in mind—what advice would you have to all the other people, among them, the Mrs. Greens and others in the world, to avoid this kind of wrenching experience?

Mr. SNOOK. Actually, you have little choice. If you are on medicaid, you have to accept the first nursing home bed that becomes available. In my mother's case, the hospital caseworker or social worker there threatened to send my mother to a nursing home in New York City if we could not find a bed for her.

So in medicaid, you have no choice. You take the first bed that becomes available. And I might point out, one of the problems in New York State is the lack of available beds. This is why there is a long waiting time, as you mentioned in your opening statement, which also runs up the medicaid and medicare costs.

Chairman HEINZ. Now, the judge, who decided in your favor, said that the reason the contract was unenforceable was that it was contrary to Federal and State law and national policy. Did you ever receive any assistance from the State or Federal governments in pursuing your rights under Federal and State law?

Mr. SNOOK. No.

Chairman HEINZ. Do you think it is right that when we have a Federal law, individual citizens should be forced, because State and Federal government apparently does not do anything to enforce the laws that we pass, do you think it is right that you should have to go and enforce the law on behalf of the Federal Government or State government?

Mr. SNOOK. I see nothing wrong with what I did, and I think that usually, this is the case. I might just mention that as a result of my hearing, the New York State Department of Health has changed its policy and no longer allows such agreements. I think you will find most times, it is the action of private citizens that accomplishes most changes, more than the Federal Government, State government, or local government.

Chairman HEINZ. Is that because we do not enforce the law?

Mr. SNOOK. No, I do not think it is because you do not enforce the law. They have got to have somebody get up there and initiate something. I think it is up to the private citizen to speak up.

Chairman HEINZ. I have one or two more questions of Ms. Edelman, but my time has expired.

Senator Burdick.

Senator BURDICK. Well, as I listened to the testimony this morning—let me try and get it all together here—what seems to be the problem is that medicaid pays at a lower rate than the nursing homes charge, and there is the gap. Is that about right?

Mr. SNOOK. That is correct.

Senator BURDICK. How do we close the gap?

Mr. SNOOK. I think you have to decide whether the rates that are being paid to the nursing homes under medicaid are fair or not. I have no way of knowing as a private citizen whether the rates the nursing home receives from New York State are fair and adequate. I think this is up to the States to determine. They supposedly have various formulas for calculating the rate of reimbursement.

There is no question that nursing homes make more money if they have private-paying patients. They would rather have private-paying patients. They make more money. The question is for the Congress to decide whether they can discriminate against people of lower economic standards on the basis of economic conditions. Nursing homes can't discriminate against blacks and Hispanics because of their lower economic conditions.

Senator BURDICK. Well, let me ask the second question I have in mind. If medicaid pays at a lower rate than nursing homes charge, does medicaid pay at a rate that would sustain the care in a home? Is there disparity there—in other words, could we replace nursing home care with home care? Are the medicaid payments adequate to meet those costs?

Ms. MOSER. In our area, we have what we call home health care centers, and that is the same as a nursing home; usually, the price is the same. When the management companies say private pay is

more money, in our facility, you were talking $5 more a day by private pay, which is really only $100 a month. But what they are saying is that medicaid waits 2 or 3 months to send the check, so if you take private pay, you are going to be getting your money from day one; you are not going to have to wait 2 or 3 months for it. And when a facility first starts out, there is no way that you can build a nursing home when it costs whatever it costs, around $1 million, to build a nursing home, and then fill it up with medicaid patients and have to wait 2 or 3 months. You have got to look at that point, too.

But there should not be a difference between medicaid and private pay. If the private pay needs a room, too, there should not be any discrimination there.

Senator BURDICK. Would anybody else like to comment on that suggestion that home care might meet the costs?

Ms. MOSER. You see, with home care, you are not getting 24-hour care.

Senator BURDICK. I understand. I am assuming by that statement that in many cases, that would not be adequate.

Ms. MOSER. No. In some, it would. Now, there were a lot of people in our nursing home who could have been home if they had just had someone to stay with them. They were physically able to stay at home, and maybe even mentally. But as far as remembering if they ate breakfast, or forgetting to eat, or forgetting to turn the stove off—people like that could remain at home if there were some way, someone to stay with them. And there is no 24-hour care at home that you can get.

Senator BURDICK. Well, then, for those who must be in a nursing home facility, there is no question but that medicaid falls short of paying the rate?

Ms. EDELMAN. Senator, the medicaid rate is lower than the private-pay rate in every State but Minnesota, but that does not mean that the rate is inadequate. Ms. Green said that the facility that took the medicaid rate for her mother, the second facility, provided as good care and perhaps better care than the first facility, which required private pay. We do know of a number of facilities that have a high proportion of medicaid recipients, and are able to provide very good care.

Giving more money does not necessarily mean the care is going to be better, and it also is not going to mean that there will not be discrimination against medicaid recipients. As long as there is a differential between the private pay and the medicaid rate, and as long as there is a shortage of beds, and occupancy rates are high, nursing homes are going to prefer private pay over medicaid. To me, $5 a day does not sound like that much money, but that is $150 a month times however many residents are in that facility times 12 facilities. That adds up, and the facilities want that extra money.

Ms. MOSER. One more thing. During the previous management company we had starting turning a profit. The nursing home that I worked at has just been open 2 years this October, and the nursing home management had—because I sat in on the department meeting—we had started turning a profit 6 weeks before this company took over, and we were doing it legally, you know, going by the waiting list. And these people came in, and they were just more

greedy, and they made the two lists. But it was turning a profit. The money was adequate, because it was turning a profit.

Senator BURDICK. But we are still left with the proposition that medicaid in general pays a lower rate than nursing homes charge, and that seems to be the problem.

Ms. EDELMAN. But that is because there is no control over the private-pay rate. Facilities can charge whatever they want, whatever they can get people to pay. There are basic rates, and then there are add-ons. If you need tube feeding, that is extra money; if you need this, it is extra. Whereas, for medicaid recipients, that might all be included in the medicaid rate, so the differential gets to be more and more, the more services the resident needs.

Mr. SNOOK. What I would like to know is why in my mother's case, medicaid rates were inadequate for the first 18 months of her care, but adequate after that; when the level of care did not change. I do not think it is a question of medicaid rates being inadequate, but that nursing homes can make more money from private paying patients.

Senator BURDICK. That is all I have, Mr. Chairman.

Chairman HEINZ. Let me just state for the record, Senator Burdick, that all of these nursing homes have the choice as to whether or not they want to participate in medicaid. They are not obligated at all to participate in medicaid. As part of their obligation, when they choose to accept medicaid patients, they are obliged not to charge, solicit, accept, receive any money, donation or other consideration for admission or continued stay of a medicaid patient in a nursing home. That is the law. That is the quid pro quo for their taking, having, as many of them do, medicaid patients. What they want to do, it seems to me, if I may say so, is have it both ways. They want to take medicaid patients when it suits them, but not take them when there is somebody they can make more money on.

But the fact is that they do take a lot of medicaid patients when it suits them. Well, if it is so unprofitable for them to take medicaid patients, why do they do it?

Mrs. Green, as Ms. Edelman pointed out, has testified that there is another nursing home which her mother went to, which took medicaid patients, did not discriminate against them, and is to be commended for following Federal law, and apparently understands the quid pro quo.

I just have one last question for—excuse me, it is not my turn. It is Senator Glenn's turn, and I yield to him, and then I will have one last question.

Senator Glenn.

Senator GLENN. You have apparently all had problems with bureaucratic gobbledegook, nonsense, one department to another, difficulty in getting a decision, who was going to pay what, where, when, and meanwhile, the care had to go on. I think that has been a pattern, and I will not ask you to comment on it, because your statements already are in that vein.

Knowing what help is available is apparently a problem. And just knowing what agency to go to and then getting an expeditious answer out of them, I gather, is a real problem.

Would you all agree with that, or would anyone take exception to that? I guess you would not.

I am concerned about that end of it, too, and the fact that we, here in Washington, are not doing much about it.

I am disappointed that Charles Baker, who is the Under Secretary, Department of Health and Human Services, who was going to be here, canceled out last week. The chairman had sent a letter to him, asking him to appear, and in his answer, which we got back from John Scruggs, Assistant Secretary for Legislation—well, let me add this. I am not doing this on a partisan basis. We had a hearing here almost 5 years ago in which I castigated the Carter administration for not doing something in this regard. And here we are, some 4½ or 5 years later, going through the same business again. So I am bipartisan in my criticism, or apolitical, whichever way you want to look at it, because this is not a brandnew problem; it is not coming out at this hearing this morning for the first time.

And the answer we get back from HHS now is—and I will read part of it—it goes through with thanking the chairman for his interest, and they want to cooperate, and all that sort of thing, and then they decline, because they are not prepared to discuss this. And it says:

> In the interim, we wish to continue our beneficial discussions with your staff, in a concerted effort to address our mutual concerns about the well-being of elderly medicaid patients. To further extend that dialog, the Secretary will appoint representatives from HCFA, OCR, the IG, and AoA, to form a formal working group to coordinate our approach to the issue. Intradepartmental coordination and projected needs for outreach will be among the key topics of study.

That is beautiful, HHS. Why don't we get something done? We can have hearings, and we can point this out, and the cameras are all here, the reporters are all here—two full tables of them over here—and yet, we are 5 years later, talking about the same old lack of coordination and intradepartmental whatever it is. I think we could get some things out in under 5 years around here, whatever administration happens to be in office, to help to straighten this out.

Chairman HEINZ. If the Senator will yield, I think he is being too mild:

Senator GLENN. Yes, well, I yield my time.

Chairman HEINZ. And for this reason.

Senator GLENN. This is 5 years old that I know of personally around here.

Chairman HEINZ. The issue is at least 5 years old, but regulations that would allow the States and the Federal agencies to enforce this part of the 1977 Social Security Act Amendments have been languishing in the Department of Health and Human Services for the last 3 years. And I am not only disappointed that the Department of Health and Human Services did not show up; I am disappointed that it has taken them 3 years to find a new way to stall in the issuance of the regulations that were mandated back in 1977.

Let me just ask for the record, Ms. Edelman, is it not true that Social Security has been drafting regulations for at least 3 years?

Ms. EDELMAN. On intermediate sanctions?

Chairman HEINZ. Yes.

Ms. EDELMAN. Yes. Those regulations have been on Carolyn Davis' desk, we are told at every meeting, but we have never seen them.

Chairman HEINZ. And is it not true that if those regulations were issued that it would go a long way to solving the problems that we have heard today?

Ms. EDELMAN. Those regulations would be one step, I believe, Senator, but they would not be adequate to solve the problem—they would help.

There are other regulations that are even longer in coming. The Department was told in 1977 to say what is included in the medicaid rate and what is not included in the medicaid rate, so people at least have an idea of what they are paying for, and those regulations have never been issued. They were told to publish them within 90 days of the enactment of the law, which was October 30, 1977. We have never seen anything on those regulations.

Chairman HEINZ. One of the suggestions you have made is to require a waiting list with receipts for nursing home admission; is that correct?

Ms. EDELMAN. That is what Connecticut has done now, yes.

Chairman HEINZ. And has that initiative in Connecticut been successful so far? Do we know?

Ms. EDELMAN. Well, we do not know, because the receipt part was just enacted in 1984. Connecticut passed an antidiscrimination law in 1980, saying people have to be admitted first come, first served, without regard to source of payment. But nobody had any idea if the facilities were actually complying with that requirement that was in the law. So in 1984, Connecticut amended its law to say, "OK, facilities, you cannot just say you are complying. You have to give people signed receipts so we can monitor what you are doing."

That was part of my testimony, that it is important to monitor whatever we require; otherwise, it is not worth the paper it is written on.

Chairman HEINZ. There are two additional levers that we have with respect to getting nursing homes to obey the law. One is the Ombudsman Program; the other is the periodic State survey and certification that is required under Federal law.

Why should not the Congress direct both the Ombudsman Program and the certification agencies to particularly focus in on the extent to which there are illegal contracts being used, as one means among many in getting this practice stopped?

Ms. EDELMAN. I think the ombudsmen are very aware of the problems, and the ombudsmen try to deal with the problems, but they do not have enforcement authority. All ombudsmen can do is negotiate, talk to people, and document problems. And what they have done, and what a lot of ombudsmen do, is go to the State legislatures, come to Congress and say: "This is a serious problem, and we need some more help in this area." So the ombudsmen are working on this area, but they do not have the tools, because they are not an enforcement agency. In terms of survey and certification, the only Federal sanction we have is decertification, and that does not make sense in this area. You are not going to say, "You are not taking medicaid recipients properly, and so our sanction is

that you cannot take medicaid recipients." That does not make any sense. You need to say: "You have obligated yourself to take medicaid recipients, and now we will ensure that you do take medicaid recipients." That is an appropriate remedy, not: "OK, you are out of the program entirely." That would just hurt our clients, anyway.

As you said, if people are transferred from one facility to another, it is very dangerous to people. Transfer trauma is a serious problem. People die when they get moved. So we do not want the remedy to be worse than what we are trying to cure. It is not healthy. We need to have more appropriate remedies, and the State agencies do not have those remedies under Federal law. That is part of what the intermediate sanctions are that we are looking for.

Chairman HEINZ. Correct. Any further questions?

Senator BURDICK. I have one last question.

Ms. Edelman, you say in your closing statement: "We cannot simply allow facilities to continue using medicaid for their own purpose and on their own terms. Being a medicaid provider must obligate each medicaid facility to provide care to the poor, the elderly, and disabled people who need its services."

Could you let me know, now or later, what regulations would take care of that?

Ms. EDELMAN. I was going to put this in my written testimony. There are examples of different approaches States are coming up with to force facilities that are providing in the program to meet the obligation to provide care to the recipients of those programs.

Chairman HEINZ. Ms. Edelman, we will submit from Senator Burdick, and I imagine, others on the committee, a not too extensive list of questions for you to respond to in writing.[1] I think Senator Burdick asked a good question, and I hope you can respond to it.

Ms. EDELMAN. Yes.

Chairman HEINZ. Just a question of a general nature. We have documented fairly clearly here today illegal practices involving the solicitation of money, in one form or another, from patients or their families, that is illegal under Federal law. Is the term "extortion" to strong a term to describe what is going on?

Mrs. GREEN. No.

Chairman HEINZ. Ms. Moser?

Ms. MOSER. No.

Chairman HEINZ. Mr. Snook, do you think it is extortion?

Mr. SNOOK. I definitely do.

Chairman HEINZ. Ms. Edelman, do you think it is extortion?

Ms. EDELMAN. It is. People have no choice. That is what they are saying. They need a nursing home bed, and the only way you can get in is to agree to pay $100 a day for 18 months, and you sign.

Mr. SNOOK. There are other forms of this that I know or have at least heard about. In my area of Long Island, there is an extreme shortage of nursing home beds, and if you send $500 or $1,000 to a said nursing home, you will within a few days find a bed available. Now, in my mind, this is plain extortion, and let us not cover it up.

[1] See appendix 1 for additional statement of Ms. Edelman.

Chairman HEINZ. I think, speaking for myself, I totally agree with that characterization.

Ms. MOSER. Senator Heinz, in Tennessee, even the hospitals know that private pay can get a room. They will call and say: "Do you have any rooms?" and you say: "No" and they will say: "Well, this is private pay." So everybody is aware that money does talk, and all of the nursing homes do it. But most of them hide it. When somebody comes in and asks, "Do you have two lists?"—they hide it.

But this management company is so sure that they can get around the regulations that they said: "No, you can show the discrimination board the two lists." There is no law that really prohibits it.

Chairman HEINZ. Thank you.

Senator Glenn.

Senator GLENN. Just one last question. Following along Senator Burdick's line of questioning a little bit, are there any of these institutions that say: "OK, we will accept medicaid patients," and they sign up under that, thinking that there will be a balance between those who pay more and the medicaid patients who pay less, and then, because they cannot keep that balance, they find themselves in tough economic trouble—is that a problem? And what is the procedure? Can they then decertify themselves to not accept medicaid patients if they want to? How do you do this? I am not familiar with that.

Chairman HEINZ. Our next witness may be an excellent witness, Senator Glenn, to answer that, the attorney general of the State of Maryland.

Senator GLENN. OK, I will just hold it, unless—did you want to comment on that, Ms. Edelman?

Ms. EDELMAN. I did want to say that nursing homes are permitted under the medicaid law to get out of the program if they want, and that has created a lot of hardship for a lot of people who have gone in as private-pay, spent their money, and 8 years later, when they become eligible for medicaid, the facility gets out. The medicaid law does not prohibit it, but some other laws may prohibit some facilities from getting out.

Senator GLENN. Is this balance between medicaid and nonmedicaid a factor, as far as you know?

Ms. EDELMAN. That is what nursing homes claim, that they have to maintain what they call a patient mix. That is the benign term that is used, and that is why they manipulate provider agreements and manipulate contracts, to maintain what they want.

Senator GLENN. Is that valid?

Ms. EDELMAN. I do not think it is valid. I would certainly not deny that some States pay an inadequate medicaid rate. But there are other States that provide a very good rate, and many facilities provide very good care with medicaid. Yet, discrimination occurs in States with high rates if occupancy rates are also high.

Mrs. GREEN. Could I say something, please?

Chairman HEINZ. Yes, Mrs. Green.

Mrs. GREEN. When my mother went into the first convalescent hospital, we were taken on a tour, and there was a little hallway—first, the place is beautiful. It is full of antiques, and it is just a

gorgeous place to look at. But you do not see what is inside until you are in there, or until you have somebody in there.

There was this hallway, and I said: "Well, let's just go down here and take a look, too."

And she said: "Oh, that is all right. That is where the Medi-Cal patients are."

I said: "Oh, you take Medi-Cal?"

She said: "Well, we prefer private pay, but after you have been here for 1 year and paid $1,600 a month, then we will keep you as a Medi-Cal patient."

And I said: "Well, why are they in here and all the other people out there?"

She said: "Oh, we just haven't gotten around to getting them out of their beds yet."

There are 126 beds in that place, and that one place owns 12, at least in northern California. Now, the fat cats are getting fatter, and it is wrong. It is wrong. And somebody has got to fight for the people who cannot fight for themselves. In my mother's case, she could not; in my father's case, he could not, because he is ill. Well, by God, I am going to, and I am going to try my darndest to make somebody out there hear me. It is wrong.

Chairman HEINZ. I think you have done a very good job right here today, Mrs. Green, and we thank you. I happen to share your feelings.

The fact is that irrespective of whether there is a difference or even an inequity between the private pay rate and the medicaid, or the Medi-Cal rate, in your case, we have a law on the books, and it ought to be enforced. And, through the enforcement of that law, we will either see if there is an underpayment in medicaid, and the various States will face up to that. But if we do not enforce the law, we make a laughingstock of the law, and clearly, we perpetuate what is gross discrimination with prejudice to the health and well-being of senior citizens, including you and the parents of just about everybody in this country because, as we pointed out earlier, two-thirds of all the middle-income people in this country who end up in a nursing home will run out of money within 2 years.

Everybody thinks, as we found 2 weeks ago, that they are protected against the costs of long-term care. Seventy-some-odd percent, according to the survey by the American Association of Retired People, think that they are protected against nursing home costs and stays, when in fact, they are not.

Mrs. GREEN. Correct.

Chairman HEINZ. And therefore, not only do people think they are protected—even if they get on medicaid, which is supposed to protect them, what we have learned from you is that they are not.

Mrs. GREEN. They are not. They definitely are not. If they are able to talk, and they are over 65 or 70, the people pay absolutely no attention to them. They write them off as senile or whatever. They do not get proper care. They are not paid enough. There are not enough nurses' aides. The ones who are there are paid minimum wage, which in California is $3.35 an hour, and some of them make $3.45 an hour. That is not enough for anybody to live on—so they steal from the patients; and nobody listens.

Chairman HEINZ. Mrs. Green, I thank you very much. You and the other members of the panel have done an outstanding job, and we thank you very much for taking all the time and trouble to be with us.

Thank you.

Our next panel now consists of one witness. It was supposed to have consisted, as Senator Glenn quite accurately pointed out, of two—a representative from the Department of Health and Human Services, who sent us a letter last week, saying that instead of appearing, they would study the problem through an interagency working group. This problem has been a problem since 1977, and there has been more than ample opportunity to study it.

Therefore, our only witness on this panel is the distinguished attorney general of the State of Maryland—no stranger to the committee, by the way. Over the years, he has testified before this committee on at least two other occasions that I am personally aware of.

So it is a pleasure to welcome Stephen H. Sachs, attorney general for the State of Maryland.

Steve.

STATEMENT OF STEPHEN H. SACHS, BALTIMORE, MD, ATTORNEY GENERAL, STATE OF MARYLAND

Mr. SACHS. Thank you very much, Mr. Chairman. It is good to be back.

I have submitted a longer written statement, Mr. Chairman, but with the committee's permission, would like to summarize it ever so briefly.

Chairman HEINZ. Without objection, your entire statement will appear in the record.

Mr. SACHS. Thank you very much, Mr. Chairman.

I welcome the chance to speak to this distinguished committee on an issue of such concern to hundreds of thousands of people in this country who are residents of nursing homes or who may someday become one. I am here to talk to you this morning about private-pay duration-of-stay clauses in nursing home admissions agreements, a provision which, in my judgment, turns medicaid policy on its head. These clauses deprive the elderly of their right to medicaid, force them and their families to pay from their own savings for care that they are legally entitled to have paid by medicaid.

Briefly stated, Mr. Chairman, these clauses demand that patients pay the nursing home at the so-called private-pay rate for a specific period of time, usually 1 year. In effect, the nursing home says to the patient: "You may come into this home only if you will pay us at the higher private-pay rate for 1 year, whether or not you become eligible for medicaid during that year."

Patients are told that they must agree to the private-pay clause as part of the admission agreement they sign before they enter a home. And the result is that, in order to make an additional $5 or $10 a day, these nursing homes deny poor people their legal entitlement to medicaid, and they prevent people who are eligible for medicaid from relying on medicaid to pay the bill. In my judgment, this is a practice that is both illegal and immoral.

As you have heard this morning, old people and their families, faced with the decision to seek nursing-home care, or to put a parent, or a wife, or a brother in a nursing home, are faced with a very difficult and sometimes very painful decision. Frequently, this decision follows years of attempts by a family to take care of the patient at home. Only when the task of taking care of that patient becomes impossible, or the patient becomes too sick, is the search for a nursing home undertaken. You know from your own constituents, and I have heard from mine, about the pain, and the guilt, and the expense that can be associated with these decisions. Imagine then, Mr. Chairman and members of the committee, the predicament such people face when they are told by the nursing home that a bed can only be made available if the patient forgoes his or her right to seek medicaid coverage, and if the patient or his family pays the nursing home the additional and, in my judgment, illegal bounty.

Now let me briefly explain why it is, Mr. Chairman, that we believe the practice is illegal under Federal law and regulation. There are three parts to our analysis. First, both the statute itself, section 1909(d)(1) of the Social Security Act, and the Federal regulations implementing that statute, require that State medicaid programs prohibit a nursing home from seeking or accepting moneys in excess of the medicaid payment rate for nursing home services. In short, they prohibit supplementation. Any damages paid for breach of a private-pay agreement would be in excess of medicaid payments and would violate this provision.

Second, Federal regulations known as the patient's bill of rights prohibit a nursing home from discharging or transferring a patient for breach of such a private-pay agreement.

Together, these two provisions make it illegal for nursing homes to prosecute a patient who breached a private-pay agreement. Private-pay agreements, therefore, are legally unenforceable.

Finally, the "patient's bill of rights" also requires that patients be told their rights, and told them accurately and fully, before they enter a nursing home. A clause in an admissions contract that deceives patients and their families into thinking that they must forego their right to medicaid obviously violates that obligation for full disclosure.

When Maryland's medicaid officials first learned of this practice, they asked my office for advice on the legality of the practice. We said it was illegal for the reasons I have just given. The State medicaid people notified all the nursing homes in Maryland that they must drop private-pay duration of stay clauses from their admission agreements, or that the medicaid program would suspend all medicaid payments to the homes. This sanction, which is permitted under Maryland's medicaid regulation, was chosen for two reasons. First, we believed it would be effective. It stops the major, if not the only, revenues many homes have. But once they have complied with the law, retroactive payment for services delivered could be made. Second, this sanction avoids the more drastic step of removing providers from the medicaid program, forcing the patients to lose medicaid benefits and face possible relocation to other homes. So I recommend for this committee's consideration particular attention to this suspension remedy.

I am pleased to report that in Maryland, most of the almost 200 nursing homes, when they learned that the attorney general had concluded that private-pay duration of stay agreements were illegal, dropped those clauses from their admission agreements. A score or so of the homes, however, are continuing to litigate the matter in Maryland. What should be of special concern to this committee, if I may echo what you, Senator Glenn, and you, Mr. Chairman, have said about HHS just a few moments ago, what should be of special concern to this committee and to Congress is the role that the U.S. Department of Health and Human Services has played or, more accurately, has refused to play, in this controversy. When the attention of Maryland medicaid officials was first drawn to this practice, they contacted program officials and attorneys in the regional offices of the Health Care Financing Administration [HCFA]. Maryland asked HFC for a reading on whether or not it was the Federal Government's position that private-pay duration of stay agreements violated Federal law. Maryland was told that HCFA agreed that private-pay clauses violated title XIX and Federal regulations. Indeed, HHS told us in Maryland that they had issued a similar opinion to the State of New Jersey in response to a query from that State. However, as far as we have been able to determine, HHS has not pursued the matter further. No letters were sent out to medicaid officials across the country, alerting them to this illegal practice. No regulations have been issued to codify HCFA's own interpretation of the law. No enforcement, as far as I can see, has occurred of any kind. In the lawsuit that was filed against Maryland that I described a few moments ago, HHS refused to participate, and asked to be dismissed from the case—refused, in short, to defend what is after all a Federal law that they say they believe in.

As we all know, when public officials blink at an illegal practice, the public loses confidence, as well it might. And it seems to me that this is an instance in which this administration is failing to exercise its responsibility to see to it that title XIX benefits are not unlawfully denied to poor people who are nursing-home patients. It is the Secretary's duty to make sure that medicaid recipients are protected in nursing homes under the standards set forth in the statute and the Department's own regulations. That duty must include making sure that no medicaid-certified nursing-home uses private-pay duration of stay contracts.

The Federal Government should be doing all that it can to assure that no resident of a nursing home, in Maryland or elsewhere, is the victim of the insidious suggestion that legitimate entitlement to medicaid may be postponed so that nursing homes may make more money than they are entitled to from their poorest patients.

Finally, Mr. Chairman, let me simply conclude by saying that as attorney general of the State of Maryland, I am keenly aware of my duty to be sure that the laws of Maryland and of the United States are fairly enforced to protect all of our citizens, but most particularly to protect those who are least likely to be able to protect themselves, especially including the poor and the elderly.

Medicaid is a significant attempt by this country to ensure that the basic health-care needs of the poorest people will be met. Prac-

tices such as the one I have described, and as the other witnesses more eloquently still have described this morning, by a major segment of the Nation's health-care industry, do little to inspire confidence that the industry is responding to the needs of the elderly in a reasonable and fair manner. And I hope that through this hearing and whatever other legislative or oversight initiatives you may pursue, you will join me in putting an end to this practice.

That is my statement, Mr. Chairman. Thank you very much. I would be very happy to respond to your questions.

[The prepared statement of Mr. Sachs follows:]

PREPARED STATEMENT OF STEPHEN H. SACHS

My name is Stephen H. Sachs. I am the attorney general of the State of Maryland. I am grateful to Senator Heinz and the members of the Senate Special Committee on Aging for the opportunity to share my views on an issue of great concern to the hundreds of thousands of people in this country who are residents of nursing homes, or who may some day become one. At issue is private pay duration of stay clauses. These clauses deprive the elderly of their right to Medicaid, force them and their families to pay from their own savings for care that they are legally entitled to have paid by Medicaid. Briefly stated, these clauses demand that patients pay the nursing home at the so-called private pay rate for a specific period of time, usually 1 year. In effect, the nursing home says to the patient, you may come into this home only if you will pay me at the higher private pay rate for 1 year, whether or not you become eligible for Medicaid during that year. Patients are told that they must agree to the private pay clause as part of the admission agreement they sign before they enter a home. The result is that, to make an additional $5 or $10 a day, these nursing homes deny poor people their legal entitlement to Medicaid; they prevent people who are eligible for Medicaid from relying on Medicaid to pay the bill. This practice is, in my judgment, both illegal and immoral.

Old people and their families faced with a decision to seek nursing home care, or to put a parent or a wife or a brother in a nursing home, are faced with a difficult and sometimes painful decision. Frequently this decision follows years of attempts by a family to take care of the patient at home. Only when the task of taking care of that patient becomes impossible, or the patient becomes too sick, is the search for a nursing home undertaken. I am sure you have all heard in testimony before this committee, and from your own constituents, as I have from mine, about the pain, and guilt, and expense that can be associated with these decisions. Imagine then the predicament such people face when they are told by the nursing home that a bed can only be made available if the patient foregoes his right to seek Medicaid coverage, and if the patient or his family pays the nursing home this additional money.

Let me tell you about a few of the people who have been affected by this practice.

A 78-year-old man suffered a stroke and was rushed to a hospital for emergency treatment. After 2 weeks in the hospital he was ready for release to a nursing home. His 76-year-old wife began visiting nursing homes in their area to find a suitable home. Although he had already been certified for medical assistance, his wife was unable to find a home willing to accept him.

A nursing home administrator explained to her that they had beds available and would be willing to accept her husband if she agreed to pay private rates for 1 year. The administrator explained that this would amount to approximately $18,000, or $1,500 per month. When the wife explained that they were retired and did not have sufficient savings to pay such an amount, the administrator advised the wife to take out a mortgage on their paid off home.

The wife, deciding she had no choice, took out a mortgage on their home. In a short period of time she found that she was unable to keep up with the mortgage payments.

A 45-year-old daughter found that she could no longer take care of her 73-year-old mother. After living with the daughter for nearly a year, the mother's condition had severely deteriorated so that she needed 24 hours a day observation. The daughter worked and was unable to pay for a home companion for her mother; she began to look for a nursing home.

Although her mother was Medicaid-eligible, no home in her area was willing to accept Medicaid patients. She therefore decided to admit her mother as a private pay patient and pay for her cost of care. She found a home in her area willing to accept her mother on that basis and signed an admission contract at that home.

In the form contract she agreed to pay 1 year's costs at the private pay rate. In the event that she breached this agreement, the contract provided for liquidated damages equal to the number of unpaid months remaining in the year times the difference between the Medicaid payment rate and the private pay rate.

Three months after the mother was admitted to the home, she died. The daughter stopped making payments to the home since her mother was no longer a patient. Although the home had long since filled the mother's bed, the daughter began to receive dunning notices from the home based on the liquidated damages cause in the contract.

An 82-year-old woman was admitted to a nursing home as a private pay patient. The woman was certified for Medicaid, but was unable to find a home willing to accept her on this basis. Her daughter therefore agreed to pay for her cost of care for 1 year.

Shortly after the mother was admitted to the home, the daughter discovered that she had incurable bone cancer and had approximately 6 months to live. The daughter called the nursing home from the hospital and told the administrator that due to her changed circumstances, she would not be able to pay private pay rates to the home.

She advised the home that they would have to seek Medicaid reimbursement for her mother since the daughter would need her savings to pay for her own care. The assistant administrator of the home called the woman back in the hospital and advised her that they would have to discharge her mother because she had breached her admission contract. The administrator asked her to what address they should send the ambulance with her mother.

Private pay duration of stay clauses thus force patients and their families to give up their right to Medicaid benefits. And for those who sign agreements with these clauses in them, there is the spectre of collection agencies, lawsuits, and eviction—and the additional expense of defending their rights to Medicaid eligibility. By forcing patients to pay, the nursing homes are raising the financial eligibility standards for Medicaid far above those set by the Congress in the law.

As I am sure this committee is aware, people who are eligible for Medicaid, and people who receive Medicaid benefits, have very little in the way of financial resources to pay for their care. The only way that they can get the care they need in a nursing home is when Medicaid pays for it. Medicaid is the principle source of payments to nursing homes for all the elderly in this country. In Maryland, medicaid recipients fill more than 61 percent of the licensed beds in the State. Nationally, nursing homes absorb almost half of all the Medicaid dollars spent. There is no way of knowing how many nursing homes have attempted to coerce Medicaid eligible patients to forego their entitlement to Medicaid in order to gain access to a nursing home bed. I know that the practice has been found in New Jersey, in California, in Michigan, in Florida in the State of Washington, and in New York.

A New York Court ruled earlier this year that private pay duration of stay agreements are illegal. *Glengariff Corp.* v. *Snook, et al.*, N.Y. Sup. Ct., Spec. Term. No. 2143/83, Jan. 4, 1984 ¶ 33,605 CCH Medicare and Medicaid Guide. The private pay agreements in that case had the effect of denying patients Medicaid eligibility for 18 months. I believe that we are talking about a widespread illegal practice that denies or delays needed nursing home services to the poorest of the poor in violation of Federal law.

Let me explain why I believe this practice violates Federal law.

First, both the statute itself, section 1909(d)(1) of the Social Security Act, and the Federal regulations implementing that statute, require that State Medicaid programs prohibit a nursing home from seeking or accepting moneys in excess of the Medicaid payment rate for nursing home services. Second, Federal regulations known as the "patient's bill of rights," prohibit a nursing home from discharging or transferring a patient for breach of a private pay agreements. Together, these two provisions make it illegal for nursing homes to prosecute a patient who breached a private pay agreement. The private pay agreements are therefore legally unenforceable. Third, the "patient's bill of rights" also requires that patients be told their rights before they enter a nursing home. A clause in an admission contract that deceives patients into thinking they must forego their right to Medicaid obviously violates that obligation. Let me explain each of these points in more detail.

Both the Medicaid statute and Federal regulations require all providers participating in Medicaid to accept Medicaid reimbursement as payment in full for the cost of services provided to Medicaid recipients. Indeed, it is criminal violation of the Medicaid statute to charge more for Medicaid services than the State reimbursement rate for that service. Section 1909(d)(1), 42 U.S.C. § 1396H(d)(1) provides that:

"Whoever knowingly and willfully charges, for any service provided to a patient under a State plan approved under this title, money or other consideration at a rate in excess of the rates established by the State shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than 5 years, or both."

In other words, once a patient is a Medicaid recipients any attempt by the nursing home to collect the $5 or $10 a day difference between the Medicaid rate and the private pay rate would violate this criminal provision of the federal law.

Federal regulations, at 42 C.F.R. § 447.15 (1981) also require that States limit participation in a Medicaid program to those nursing home providers who will accept, as payment in full, the amounts paid by the State Medicaid agency. A nursing home that tried to collect damages from a Medicaid patient for an alleged breach of a private pay agreement would violate the law because the damages would be sought for a period during which the patient is a medical assistance recipient. Obviously, any damages to be collected would be designed to compensate the nursing home for the $5 to $10 a day difference between the private pay and the Medicaid payment rate. The damages would therefore be illegal supplementation of the rates paid by the State under the Medicaid program. The court in the New York case I referred to earlier, *Glengariff Corp.* v. *Snook*, outlawed a private pay duration of stay agreement under the illegal supplementation theory, based on the same provision of the Federal law I have cited here.

Federal and State conditions for participation by nursing homes in Medicare and Medicaid establish rights of all nursing home residents, no matter what their source of payment. These conditions, known generically as the "patient's bill of rights," are found at 42 C.F.R. § 442.311. Among the rights listed is the following:

"The [nursing home] must have written policies and procedures that insure the following rights for each resident: * * * (c) *Transfer or discharge.*—Each resident must be transferred or discharged only for (1) medical reasons; (2) his welfare or that of other residents; or (3) nonpayment except as prohibited by the Medicaid program."

Violation of a private pay agreement is not a permissible basis for transfer or discharge of a patient under Federal law. It is not one of the three grounds enumerated in the patient's bill of rights for involuntarily transferring or discharging a patient. Therefore, a nursing home may not discharge a patient who converts to medicaid reimbursement during the time that he or she is a private day patient.

Finally, I believe that a private pay duration of stay agreement violates the patient bill of rights requirement that each Medicaid recipient be "fully informed, before or at the time of admission, of his rights and responsibilities and of all rules governing resident conduct." 42 C.F.R. § 422.311. A private pay duration of stay clause in an admission contract misleads nursing home residents as to their rights with regard to Medicaid eligibility; it violates the patient's right to know and the nursing home's duty to inform. In fact, a private pay duration of stay clause in a contract may induce the patient to believe that during the first year in the nursing home, despite eligibility for Medicaid, he or she may not apply for Medicaid benefits. That clause is illegal, and it is unfair. It is unfair because even if a patient suspected that the clause might be illegal, people entering nursing homes and their families are rarely in a position to bargain about such matters. In the law, such unequal bargaining power suggests a contract of adhesion. I believe that such clauses are void as against public policy, both as that policy has been spelled out by the Congress, and according to fundamental principles of fairness upon which all law should be based.

You may be interested to learn that in Maryland, the use of these clauses also violates the State's Consumer Protection Act. (Commercial Law Article, § 13-301, Annotated Code of Maryland (1981).) That law defines unfair or deceptive trade practices to include any "(1) * * * misleading oral or written statement * * * which has the capacity, tendency, or effect of deceiving or misleading consumers * * * (3) Failure to state a material fact if the failure deceives or tends to deceive." Such deceptive trade practices are prohibited by Maryland's Consumer Protection Act, which is applicable to nursing homes and other health care institutions. 63 Op. Att'y General 183 (1978). It is possible that other State consumer protection laws are likewise violated by private pay duration of stay clauses.

When Maryland's Medicaid officials first learned of this practice, they asked my office for advice on the legality of the practice. We said it was illegal. The State Medicaid people notified all the nursing homes in Maryland that they must drop private pay duration of stay clauses from their admission agreements or the program would suspend all Medicaid payments to the home. This sanction, which may be unique to Maryland, was chosen for two reasons. First, we believed it would be

effective. It stops the major—if not the only—revenues the homes have. But once they have complied with the law, retroactive payment for services delivered could be made. Second, this sanction avoids the more drastic step of removing providers from the Medicaid program, forcing their patients to lose Medicaid coverage, and face possible relocation to other homes. I recommend, for this committee's consideration, particular attention to this remedy.

I am pleased to report that most of the almost 200 nursing homes in Maryland, when they learned that the attorney general had concluded that private pay duration of stay agreements were illegal, dropped these clauses from their admission agreements. A score or so are continuing to litigate the matter in Maryland. What should be of special concern to this committee and to the Congress is the role that the U.S. Department of Health and Human Services has played in this controversy. When the attention of Maryland Medicaid officials was first drawn to this practice, in 1981, they contacted program officials and attorneys in the regional office of the Health Care Financing Administration. Maryland asked HHS for a reading on whether or not it was the Federal Government's position that private pay duration of stay agreements violated Federal law. Maryland was told that HCFA agreed that private pay clauses violated title XIX and Federal regulations. Indeed, HHS told us in Maryland that they had issued a similar opinion to the State of New Jersey in response to a query from that State's officials. However, as far as we have been able to determine, HHS has not pursued the matter further. No letters were sent out to Medicaid officials across the country alerting them to this illegal practice. No regulations have been issued to codify HCFA's own interpretation of the law.

As we all know, when public officials blink at an illegal practice and look the other way, the public loses confidence, as well it might. It seems to me that this is another instance in which this administration is failing to exercise its reponsibility to see to it that title XIX benefits are not unlawfully denied to poor people who are nursing home patients.

This Congress has recently had occasion to note the administration's failure to enforce Medicaid rules in nursing homes. Your recent conference report on the Deficit Reduction Bill of 1984, H.R. 4170, reminds the Secretary of Health and Human Services that she has the duty both to assure that the standards for care of Medicaid nursing home patients are adequate to protect the patients' health and safety, and to assure that States enforce those standards. (H. 6740 Congressional Record, June 22, 1984). The Secretary's duty to make sure that Medicaid recipients are protected in nursing homes under the standards set forth in the statute and the Department's own regulations must include making sure that no Medicaid-certified nursing home uses private pay, duration of stay contracts. The Federal Government should be doing all that it can to assure that no resident of a nursing home, in Maryland or elsewhere, is the victim of the insidious suggestion that legitimate entitlement to Medicaid may be postponed so that nursing homes may make more money than they are entitled to from their poorest patients.

As attorney general of the State of Maryland, I am keenly aware of my duty to be sure that the laws of Maryland and of the United States are fairly enforced to protect all of our citizens, but most particularly to protect those who are least likely to be able to protect themselves, including the poor and the elderly. Medicaid is a significant attempt by this country to insure that the basic health care needs of the poorest people will be met. Practices such as the one I have described by a major segment of the Nation's health care industry do little to inspire confidence that the industry is responding to the needs of the elderly in a reasonable and fair manner. I hope that through this hearing, and whatever other legislative or oversight initiatives you may pursue, you will join me in putting an end to this practice.

Chairman HEINZ. Mr. Attorney General, I commend you on a most succinct and to-the-point statement. You have illustrated quite clearly, I think, to the committee the reasons why the practices we have heard about today are illegal, contrary to Federal statute, contrary to good practice.

Let me just ask you the $64 question: What should the Federal Government be doing about these discriminatory practices? What should we in the Congress do, as well?

Mr. SACHS. Well, the Federal Government—speaking specifically of HHS, Mr. Chairman—should be doing is its job. They have said, sort of privately and in letter form, that the practices we have been describing are illegal.

But how how about a memo to all of the program officials throughout the country, alerting them to this illegal practice?

How about a program letter, which they use, certainly, whenever they wish to alert program officials throughout the country to the practices that ought to be uniform.

How about the adoption of a regulation—if anybody should think that clarification is necessary—a regulation making clear beyond any doubt—that these practices are illegal?

Finally, of course, what it should be doing is enforcing the law, and that includes U.S. attorneys throughout the country when criminal violations are called to their attention.

Chairman HEINZ. Mr. Attorney General, we have been told by nursing homes that they simply cannot accept more than a certain percentage of medicaid patients in order to stay in business. The nursing homes have said, and I suspect they will say today, that when they accept 50 or 60 percent medicaid patients, that they should be entitled to refuse to accept anymore medicaid patients. What do you think—is that justified?

Mr. SACHS. Well, I am not an expert, Mr. Chairman, on the economics of nursing homes. But both in my capacity as counsel to our health agencies in Maryland and as a law enforcement official charged with the enforcement of medicaid fraud provisions of the law which occasionally touch the nursing home industry, I think I have had some exposure to it.

What I know is that, as was described here earlier this morning, investment counselors tout nursing home stock as investment worthy, and it has become a very profitable investment for a great many people.

I know that in Maryland, over half of our medicaid expenditures go into the nursing home industry. I know that 60-some percent of all the beds in the nursing homes in Maryland are medicaid funded.

In short, Mr. Chairman, what I know is that medicaid is the cash register of the nursing home industry. And there would not be a nursing home industry in anything like its profitability if it had not been for the Congress of the United States passing this important piece of legislation. But what should not be overlooked is that it was passed not for the benefit of the nursing home industry, but for the benefit of those who need the services of nursing homes, namely, the elderly and the poor.

So, whether or not the industry would be as profitable if they were not required to obey the law, if it would not be as profitable if they were not permitted to discriminate in any way—I really cannot speak to that. But I think I can say that it is certainly my conclusion that they ought not be heard to say that they cannot afford to obey the law.

Chairman HEINZ. Mr. Attorney General, you are to be specifically commended in the strongest possible terms for the excellent job that you have done protecting patients' rights in the State of Maryland, and the committee does commend you.

Mr. SACHS. Thank you.

Chairman HEINZ. Other States are not so fortunate at this point to have their people so well protected. You have successfully dealt with the issue of private-pay agreements. What advice would you

have to a medicaid recipient in another State who signed a private-pay agreement and now discovers that he or she is not required to pay that fee?

Mr. SACHS. Well, it is a sad piece of advice to give, Mr. Chairman, but in the final analysis, that person, that person's family, needs and ought to seek some kind of legal advice—if they cannot afford private legal advice, then Legal Services—to the extent Legal Services has been left viable in the United States—is available to be helpful. But if sued by a nursing home, they need protection. They need the kind of protection that Mr. Snook had and exercised successfully in New York.

I can only say that I hope it is true that other attorneys general throughout the United States, and consumer protection divisions around the country, are available to counsel such persons, and perhaps in some cases, be of assistance. I would hope that my colleagues around the country would take a position similar to the ones that we have taken—and I have no reason to think that they would not, if their attention is addressed to it. That is another reason why Federal policy is so important. To collect 50 different State law departments and get them all on the same wavelength is really much easier if there is a Federal policy that is articulated and strong.

Chairman HEINZ. Mr. Attorney General, I thank you.

Let me first call on Senator Burdick and then, Senator Glenn.

Senator BURDICK. Welcome to our committee.

Mr. SACHS. Thank you.

Senator BURDICK. I have been reading and listening carefully to your testimony this morning, and it is your contention that the *Glengariff Corp.* v. *Snook* New York Supreme Court decision outlaws private-pay agreements. Have there been any contrary holdings any place in the country?

Mr. SACHS. I know of no contrary holding, Senator. The matter, as I said in my testimony, is being litigated in my State, in Maryland. Following our opinion in 1982, most of the nursing homes complied with the ruling that we made. But about two dozen challenged us, and that is now in the final stages of an administrative proceeding in Maryland. This week, as a matter of fact, the final hearing in the administrative process will occur. We have been successful so far. I predict that we will continue to be successful. But I would not be surprised if the nursing homes, then, take us into court to challenge the administrative holdings.

I know of no contrary rulings around the country, Senator.

Senator BURDICK. Is the same question involved in these other cases?

Mr. SACHS. Essentially.

Senator BURDICK. Well, isn't the *Glengariff* case pretty much persuasive in the courts?

Mr. SACHS. We, of course, welcome it, and we argue it. But as I am sure you know, Senator, it is not necessarily binding on the courts of any other State, so it is helpful to our cause, and it is perhaps persuasive, but it is not controlling.

Senator BURDICK. The *Glengariff Corp.* case did not go to any higher court, did it?

Mr. SACHS. Not that I know of, Senator, no.

Senator BURDICK. This party to the action, Mr. Snook, is he one of the gentlemen who testified here this morning?

Mr. SACHS. Yes, sir. He was the man sitting here.

Senator BURDICK. Thank you very much.

Mr. SACHS. Thank you, sir.

Chairman HEINZ. Senator Glenn.

Senator GLENN. Thank you, Mr. Chairman.

We revised our law in Ohio in this regard back about—in fact, it went into effect in July 1983. I think it has been looked at by a number of States as—I do not know that it is a model, or that it is perfect, but it has been looked at, I know, by a number of States as being sort of exemplary of what can be done. I do not know whether you are familiar with it or not, but Mr. Chairman, I would like to have just this little short code from Ohio entered into the record, so that we can have an indication in this committee hearing record of what can be done, and perhaps you will have other suggestions to make after you have reviewed something like that, also, and what your experience would indicate what should be done here.

Chairman HEINZ. Without objection, so ordered.

[The code referred to by Senator Glenn follows:]

5111.31 Additional terms in provider agreements after July 1, 1983

(A) On and after July 1, 1983, every provider agreement with a home shall:

(1) Prohibit the home from failing or refusing to retain as a patient any person because he is, becomes, or may, as a patient in the home, become a recipient of assistance under the medical assistance program. For the purposes of this division, a recipient of medical assistance who is a patient in a home shall be considered a patient in the home during any hospital stays totaling less than twenty-five days during any twelve-month period. Recipients who have been identified by the department of public welfare or its designee as requiring the level of care of an intermediate care facility for the mentally retarded shall not be subject to a maximum period of absences during which they are considered patients if prior authorization of the department for visits with relatives and friends and participation in therapeutic programs is obtained under rules adopted under section 5111.02 of the Revised Code.

(2) Include any part of the home that meets standards for certification of compliance with federal and state laws and rules for participation in the medical assistance program;

(3) Prohibit the home from discriminating against any patient on the basis of race, color, sex, creed, or national origin.

(4) Prohibit the home from failing or refusing to accept a patient because he is, becomes, or may, as a patient in the home, become a recipient of assistance under the medical assistance program if less than eighty per cent of the patients in the home are recipients of medical assistance.

(B) Nothing in this section shall bar any religious or denominational home that is operated, supervised, or controlled by a religious organization from giving preference to persons of the same religion or denomination. Nothing in this section shall bar any home from giving preference to persons with whom it has contracted to provide continuing care.

(C) Nothing in this section shall bar any county home organized under Chapter 5155. of the Revised Code from admitting residents exclusively from the county in which the county home is located.

(D) No home with which a provider agreement is in effect shall violate the provider contract obligations imposed under this section.

(E) Nothing in divisions (A) and (B) of this section shall bar any home from retaining patients who have resided in the home for not less than one year as private pay patients and who subsequently become recipients of assistance under the medicaid program, but refusing to accept as a patient any person who is or may, as a patient in the home, become

a recipient of assistance under the medicaid program, if all of the following apply:

(1) The home does not refuse to retain any patient who has resided in the home for not less than one year as a private pay patient because he becomes a recipient of assistance under the medicaid program, except as necessary to comply with division (E)(2) of this section;

(2) The number of medicaid recipients retained under this division does not at any time exceed ten per cent of all the patients in the home;

(3) On July 1, 1980, all the patients in the home were private pay patients.

HISTORY: 1983 H 291, eff. 7-1-83
1983 H 100; 1981 H 694; 1979 H 176

Note: 1983 H 291, § 160, eff. 7-1-83, reads:

Notwithstanding sections 5111.02 and 5111.31 of the Revised Code as amended by this act, for the twelve-month period ending October 31, 1983:

(A) The maximum period of temporary absences for hospitalization during which a nursing home patient who is a recipient of medical assistance shall be considered a patient in the home shall be thirty days.

(B) The maximum period during which payments may be made under the medical assistance program to reserve a bed for a medical assistance recipient shall not exceed the maximum period specified under federal regulations and shall not be more than twenty-four days for hospital stays, visits with relatives and friends, and participation in therapeutic programs outside the home. Residents of an intermediate care facility for the mentally retarded shall not be subject to a maximum period during which payments may be made to reserve a bed.

5111.32 Judicial remedies

Any patient has a cause of action against a home for breach of the provider agreement obligations or other duties imposed by section 5111.31 of the Revised Code. The action may be commenced by the patient, or on his behalf by his sponsor or a resident's rights advocate, as either is defined under section 3721.10 of the Revised Code, by the filing of a civil action in the court of common pleas of the county in which the home is located, or in the court of common pleas of Franklin county.

If the court finds that a breach of the provider agreement obligations imposed by section 5111.31 of the Revised Code has occurred, the court may enjoin the home from engaging in the practice, order such affirmative relief as may be necessary, and award to the patient and a person or public agency that brings an action on behalf of a patient actual damages, costs, and reasonable attorney's fees.

HISTORY: 1979 H 176, eff. 7-1-80

Senator GLENN. I have been advised that when family members seek help, often, a nursing home ombudsman or something like that is brought in, and when suit is filed, it almost is invariably the case that the nursing home will reduce its demands on people who are trying to get services.

Has that been your experience in Maryland?

Mr. SACHS. Well, somewhat, Senator. I am not sure what you mean by "reduce its demand." Do you mean——

Senator GLENN. Well, for additional payment, or a year's private payment before they will admit someone.

Mr. SACHS. Well, I can only say that the great majority of the nursing homes in Maryland when we issued our ruling did comply, but some two dozen—and of course, this represented threatened suspension of payments, and it represented the official position of the State's attorney general and the program people—but some two dozen, including some of the larger ones and the more powerful ones in the State, are continuing the practice yet today, and until we get the matter finally litigated, will continue to do so.

The question has been asked here, Senator, about how widespread the practice is. I do not have to go beyond the statements of the homes themselves in Maryland and the pleadings in our case. They refer to this as—and this may not be a quote, but it is very close—as a widespread, time-honored practice that has been going on since the beginning of the Medicaid Program. So I think we have an admission as to its widespread nature.

Senator GLENN. In Ohio, we have seen some nursing homes withdraw from participation in the medicaid program. Do you believe that enforcement of the laws to prohibit discrimination against medicaid patients will lead to more of that, and perhaps a two-tiered system of medical service and nursing home care?

Mr. SACHS. I do not see that, Senator. For example, in Maryland, it has not happened. Not one home has sought to withdraw—now, mind you, there are 24 of them still in litigation, but that has not happened.

Second, the remedy we have used in Maryland, the suspension of payments is something short of the termination of the privileges. But finally, Senator, I continue to believe this is very profitable business. The nursing home business is very profitable, whether it is—perhaps we are talking here about the difference of whether it is superprofitable or just very profitable. But I do not see people leaving a business that is a profitable one.

Senator GLENN. Once you tightened up on enforcement of the law and took the action you did in Maryland, have any of the homes gone out of business due to the legal action you took?

Mr. SACHS. No, sir.

Senator GLENN. None?

Mr. SACHS. None.

Senator GLENN. Mr. Chairman, I would only add one thing. This is something that in our own family, we have had a long interest in. Well, before I was in the Senate, my wife worked with the Nursing Home Association in Ohio and actually visited a great number of the homes and checked into them, stayed overnight. It was quite illuminating, and from that came some of my own inter-

est with her coming back and telling some of the stories about what was going on in some of these homes.

I am happy to say, most of the experiences were good, the people were being taken care of. But there were abuses that she came back very, very concerned about, and it is something that must concern all of us. We are all getting older day by day, and a lot of us will wind up there one of these days, and I would like to see these places made as good as possible before I arrive, thank you. That may put it on a selfish basis, but it is a fact, nevertheless. We have families now spread out all over the country. My own family is not exceptional, in that my wife and I are here in Washington, a daughter is in Colorado, and a son is in San Francisco. Families are not in the same community all the time to take care of people, and certainly, in today and age, supposedly an enlightened age and concerned for others, we certainly can take a Federal responsibility in seeing that those who cannot take care of themselves should have decent help.

I remember Annie coming back, talking about going in one place, and a man breaking into tears when she walked into the room because he had not had a single visitor in the previous 2 years, I believe it was, except just the nursing home people who were in and out of his room from time to time. So perhaps all of us need to take a little bit more concern about this and the people in the homes, not just our own families, but others, too, because we are all heading in that direction sometime.

Thank you.

Mr. SACHS. I agree with that, Senator, and I would like to associate myself with it. If I may add just one thought of my own, I too have walked the halls of a great many nursing homes to visit and to see what the conditions are like, and many of them—many of them—are good places, caring places, attempting to deliver on the contract they make with the patients who come. And even on this question, I think that there are a great many nursing homes which, if only there were a clear statement of policy from those who know it best—namely, HHS—would comply with the law. A lot of the noncompliance, I think, is a direct result of the inattention to duty, in my judgment, of HHS. They could make life an awful lot better for an awful lot of families around this country by issuing just one program bulletin, concurring with the kind of interpretation that we have been talking about.

Senator GLENN. Most of the people in the nursing homes, I think, are very compassionate, they are concerned, and that is the reason they work there. And most of these places are taking excellent care of people. But there are abuses, even in the best of homes, that are tragedies of our human condition, and we just should not let that go ahead. So those are the abuses that we want to correct.

Mr. SACHS. Yes.

Senator BURDICK. Mr. Chairman, I have one question.

Chairman HEINZ. Senator Burdick.

Senator BURDICK. Since the decision in the *Glengariff* case, do you know of or have you heard of any nursing home that has refused to accept patients?

Mr. SACHS. None in Maryland, Senator, no. We do not know of any who have changed their policies, who have refused to accept patients because of that.

Senator BURDICK. Thank you.

Chairman HEINZ. Senator Burdick, thank you.

Steve, thank you very much. It was a great pleasure, and thank you for being such an excellent witness. We appreciate it.

Mr. SACHS. Thank you very much, Senator, and I commend the committee for its very, very good work.

Chairman HEINZ. Our last witness is Dr. Paul Willging, representing the American Health Care Association.

Dr. Willging, thank you very much for being here. Please proceed.

STATEMENT OF DR. PAUL R. WILLGING, DEPUTY EXECUTIVE VICE PRESIDENT, AMERICAN HEALTH CARE ASSOCIATION, WASHINGTON, DC

Dr. WILLGING. Thank you, Mr. Chairman.

It is a pleasure to be with you today. In the interest of brevity, I have also submitted written testimony, and with your permission, I would suggest it be inserted.

Chairman HEINZ. Without objection, your entire testimony will be a part of the record.

Dr. WILLGING. And I will try to briefly summarize what it is I have to say on this issue.

I am with the American Health Care Association, the largest nursing home association in the country. I think it is important that we discuss the problem of access to nursing home care, a problem which, I submit, goes beyond the problems of medicaid patients, and given what is happening in this country and within the States, can deal, in fact, with the private pay patients' access to the nursing home, as well.

Do we have a problem? We clearly have a problem. It needs scrutiny.

My concern, Mr. Chairman, based on what I have heard today, is that you have dealt with the symptoms of the problem and not with the problem itself. And I would submit, quite categorically, that the problem relates to policies consciously and with full understanding of intent which have been implemented by a number of the States; policies which relate to the funding of a good part of nursing home care in this country.

I think what we have seen over the past few years, for reasons that I can perhaps understand, although not agree with, are conscious attempts by the States to arbitrarily limit the supply of nursing home beds in this country and to arbitrarily impose price controls over the services which are provided by those nursing homes.

I think we have had enough experiences in this country to know what happens when one attempts to tamper with the market by arbitrarily constraining either supply or price.

With respect to supply, it is understandable why States have attempted to limit the number of nursing home beds available. Medicaid is the largest growing component of most State budgets. Long-

term care accounts for 44 percent of most States' medicaid expenditures. Therefore, by impound limits on beds in the State available for long-term care, the State stands a very good chance of being able to effectively control its medicaid budget.

We already have, in 16 States, moratoria on new nursing home bed construction, moratoria that are either explicit or implicit. We have in two States, at least, Tennessee and Mississippi, a much more direct approach to dealing with the problems of medicaid access to nursing beds. They have simply decided that they will contract for, under their licensure provisions, only x beds per year available to medicaid patients.

We have other States that have been somewhat more innovative. They have essentially suggested that nursing home beds can be constructed as long as there is no chance that a medicaid patient will end up in that kind of bed. For example, Florida and New Jersey have exempted from the certificate of need program nursing homes constructed in life care communities—a life care community is, more often than not, a service provided for middle-class America—but for all other nursing home beds for which a medicaid patient might be eligible, those nursing home beds are still subject to certificate of need provisions.

So we quite clearly have, whether one calls it the generation of a "seller's market," arbitrary constraints on supply as far as the nursing home industry is concerned.

Couple that with the constraints on pricing, and we clearly should not be surprised that we have a problem in terms of access. Any enterprise, private, public, proprietary, or nonprofit, has got to cover its costs. The only exception I am aware of in terms of that basic economic rule is the Federal Government. The result is that in the nursing home area, to cover the costs of the care provided—and let me emphasize that most nursing home administrators in this country are not inclined to want to provide the very minimal care that is mandated by Federal or State statute and regulation—facilities provide what they consider to be an acceptable level of care, care that is not, in many States, adequately reimbursed by the Medicaid Program. There is a requirement, referred to previously by Ms. Edelman, for a mixing of the private-pay and the medicaid patients. There is no option other than either fiscal insolvency or a reduction in the quality of the care.

Twenty percent of State medicaid programs, Mr. Chairman, provide the $35 or less per day for a day of nursing home care under the medicaid program. Some States provide in the $20's. I suggest we analyze what that means—$35, $27, $28 for a day of nursing home care. We have trouble nowadays finding a hotel or motel room for $35, yet we are talking about in the nursing home arena, a day of room and board, skilled nursing care, recreational activities, social activities, the entire gamut of activities that makes up a day of nursing home care.

Governmental facilities, including those in the State of Pennsylvania, Mr. Chairman, have access to subventions through county governments. Nonprofit facilities have access to subvention in terms of access to some of the affiliated religious organizations. The proprietary nursing home, which is 80 percent of nursing homes in this country, has access only to the private-pay market to

maintain that balance which will allow the continued provision of adequate care.

Indeed, we have indications by Dana Petrovsky, who is the licen-

tients goes up, one often finds the quality of care goes down, because you do not have that ability any more to provide for adequate resources.

Price has a similar impact in terms of ability to accept the heavier care patient in the program. If, in fact, the rates are not sufficient, one has an obligation not to accept heavy care patients who, in effect, cannot be adequately cared for.

So, I think we do have a problem. I would suggest that this committee look, however, at some of the underlying causes of that problem, that we not continue to emphasize the symptoms of the problem which we do know exist. There are solutions.

I think one of the solutions, Mr. Chairman, is the one you have suggested, that if we can in fact find ways of gathering other resources available to the long-term care needs of an elderly American, such as independent living insurance, so that the medicaid funding, which is becoming ever more constrained, can more adequately deal with the medicaid patients who do not have access to insurance or other forms of taking care of their long-term care needs, perhaps we have there the germ of a solution.

I thank you for your attention. I would be happy to respond to any questions you may have.

Chairman HEINZ. Dr. Willging, thank you very much.

[The prepared statement of Dr. Willging follows:]

PREPARED STATEMENT OF DR. PAUL WILLGING

I am Dr. Paul Willging, deputy executive vice president of the American Health Care Association (AHCA). AHCA is the Nation's largest association of long-term care providers, with a membership of over 8,600 facility based providers. This includes both proprietary and nonproprietary facilities providing a wide range of services in a variety of institutional settings. Our association is dedicated to quality long-term health care for the Nation's elderly convalescent and chronically ill.

We appreciate the opportunity to present our views on discrimination against the poor and disabled in nursing homes. We agree with the Aging Committee that such actions are of major concern to the growing elderly population who currently or in the future may require the services provided in a long-term nursing home facility. Furthermore, it is imperative that the Congress become familiar with this problem since, without Federal intervention and assistance, the situation is likely to become even worse. However, the point to be reckoned with in dealing with this concern is that there is not one simple answer which will solve the problem. Indeed, we are aware of a number of States, faced with a rapidly growing population of elderly residents requiring long-term health care services, which have sought to implement mechanisms would further limit the accessibility of these services. The result of such action has in most cases exacerbated rather than eliminated the problem. Often the quality of care to patients is diminished in the process or, in some cases, the long-term care facility chooses to withdraw from the Medicaid program thus causing an even greater shortage of critically needed nursing home beds.

Accessibility to nursing homes is indeed becoming a growing concern in this country, not only for the poor and disabled, but for private pay patients as well. The reason for this dilemma is complex and relates to a number of issues including: Control of nursing home bed supply, State medicaid reimbursement policies, and heavy patient care.

We will briefly discuss the effects of each of these on accessibility.

CONTROL OF NURSING HOME BED SUPPLY

States are implementing other types of mechanisms which influence the availability of long-term care services for the elderly.

Moratoria on nursing home bed supply

At least 16 States have imposed some form of moratorium on the construction of new nursing home beds. The types of moratoria may be informal, as in New York, Virginia, Rhode Island, and Vermont; indefinite as in Minnesota and New Hampshire; or mandated as in Missouri, South Carolina, Georgia, Alabama, Louisiana, Mississippi, Kentucky, North Carolina, Tennessee, and West Virginia. In all cases, however, the certificate of need (CON) agency in the State is responsible for implementing the informal or "mandated" moratorium.

Cap on nursing home beds

Two States, Washington and Wisconsin, are taking a second approach, but one that is similar to a moratorium, i.e., placing a "cap" on the number of total nursing home beds in the State. For example, the nursing home bed "cap" in Wisconsin allows for new nursing home development only if there are fewer beds licensed than allowed by the cap. The method of distributing new beds is still being developed. The cap will not be raised until the 1985–87 biennium. The actual raising of the cap will require legislative action. Wisconsin will also be lowering its cap if the Medicaid waiver request to creat community service slots is approved.

Other approaches

Some States are beginning to view the way the bed will be paid for as a determinant of whether it should be built. Maine has developed a policy that the Department of Health will approve nursing home beds only if the legislature agrees to fund them. Florida has developed a separate category and special formula for nursing home beds in life care communities, which will be used essentially by private pay members of the community. New Jersey has also developed a policy that exempts nursing home beds in life care communities from CON coverage. States such as Alabama and Oregon have revised their bed need criteria, limiting the number of beds per 1,000 to control nursing home supply.

Efforts to control the nursing home bed supply are effective in achieving short-term savings. However, in the long run. State costs to revive the industry will outweigh this short-term saving. In the meantime, the Nation's elderly suffer: both those who gain access to the system and those who do not. They will be the victims of short-sighted cost containment efforts of States which do not understand the nature, dynamics, and incentives of the nursing home industry.

STATE MEDICAID REIMBURSEMENT POLICIES

In addition to arbitrary constraints on bed supply, many State Medicaid reimbursement programs are similarly driven by budgetary concerns. the result is a program of inadequate reimbursement that tacitly encourages a lessened level of quality care to Medicaid beneficiaries. Many State payment systems are developed for short-term budgetary reasons without any long-term or strategic planning objective (i.e., a comprehensive goal directed toward long run savings, quality care, and pricing efficiency in the wake of a growing demand for long-term care services). State reimbursement policies often exclude reasonable long-term financing arrangments which would effectively reduce program costs or place emphasis on quality care for program beneficiaries.

The source of nursing home funds is generally split between Medicaid and private pay patients, although the percentage of each varies among facilities and from State to State. Medicaid rates paid by a number of States figure significantly in restricting the number of beneficiaries which can be admitted to a nursing facility. Unless the home balances its patient load with a certain percentage of private pay patients (depending upon geographical location and the home's particular financial circumstances), quality of care for both types of patients diminishes. The higher reimbursement rate received from private patients serves to offset the limited rates received for Medicaid patients. The result is a higher standard of care for all the facility's residents. Medicaid patients benefit from the increased number of services provided, even though they aren't paying for them. Convorsely, the smaller the number of private pay patients, the less number of services will be available to all the residents in a facility.

According to the 1983 Health Care Financing Administration Analysis of State Medicaid Program Characteristics, one-fifth of the States pay reimbursement rates

of less than $35 per day for skilled nursing facility care. Quality of care is difficult to provide when payment for services is so minimal. Even in the State of Pennsylvania, rates vary with the type of long-term care facility providing the service. County run homes often supplement State reimbursements while nonprofit facilities go to their religious affiliation for added resources. The propriety home has no alternative other than the private pay market to assure the resources necessary to provide quality care to both the Medicaid and private pay patient.

HEAVY PATIENT CARE

Currently, many States utilize rate structures that ignore differences in patient needs. Such systems encourage nursing homes to accept light care patients and avoid heavy care patients. The costs of care are different, but reimbursement levels are the same. What's more, limited payment levels prevent the nursing home from hiring adequate manpower to provide services for these individuals. As a result, heavy care patients often remain in hospitals and increase Medicare costs. Without consideration of patient needs in the development of medicaid reimbursement rates, nursing homes are compelled to give preference to light care patients so as to assure quality of care to all the residents.

CONCLUSION

In conclusion, we again concur that there is indeed a problem with respect to accessibility to long-term health care. However, we believe that policies which States have adopted to control the bed supply and limit Medicaid reimbursement rates for skilled nursing facilities have had a considerable effect on exacerbating this dilimma.

It is understandable that the growing elderly population and the anticipated health care services they will require is cause for concern due to increasing constraints on Federal and State budgets. States have no recourse but to take matters into their own hands to remedy the situation. The concern for this course of action, however, is that the solution is short-term and temporary—only a sympton of the condition has been treated, not the cause. Ultimately, a crisis will occur.

We applaud you, Mr. Chairman, for your efforts in attempting to find solutions to this serious problem. Your recent hearing which explored the costs of caring for the chronically ill was an important first step in this process. It is essential that a mechanism such as your proposed independent living insurance approach be given serious consideration by the Congress as an alternative for financing long-term health care.

As a followup to this action, we believe a comprehensive review, perhaps initiated by the Special Committee on Aging, is necessary to explore this issue further and develop solutions to lessen its impact. AHCA stands ready to provide assistance and work with committee staff toward that end.

We would be pleased to answer your questions.

Chairman HEINZ. Dr. Willging, you say that medicaid rates are too low in a number of States, $35 or less. Would you submit to the committee a list of those States?

Dr. WILLGING. I would be happy to submit a list of the rates in all States, Mr. Chairman.

[Subsequent to the hearing, Dr. Willging submitted the following material:]

Analysis of State Medicaid Program Characteristics

1983

December 1983
Prepared under Contract No. HCFA 500-81-0040
For the Health Care Financing Administration
U.S. Department of Health and Human Services

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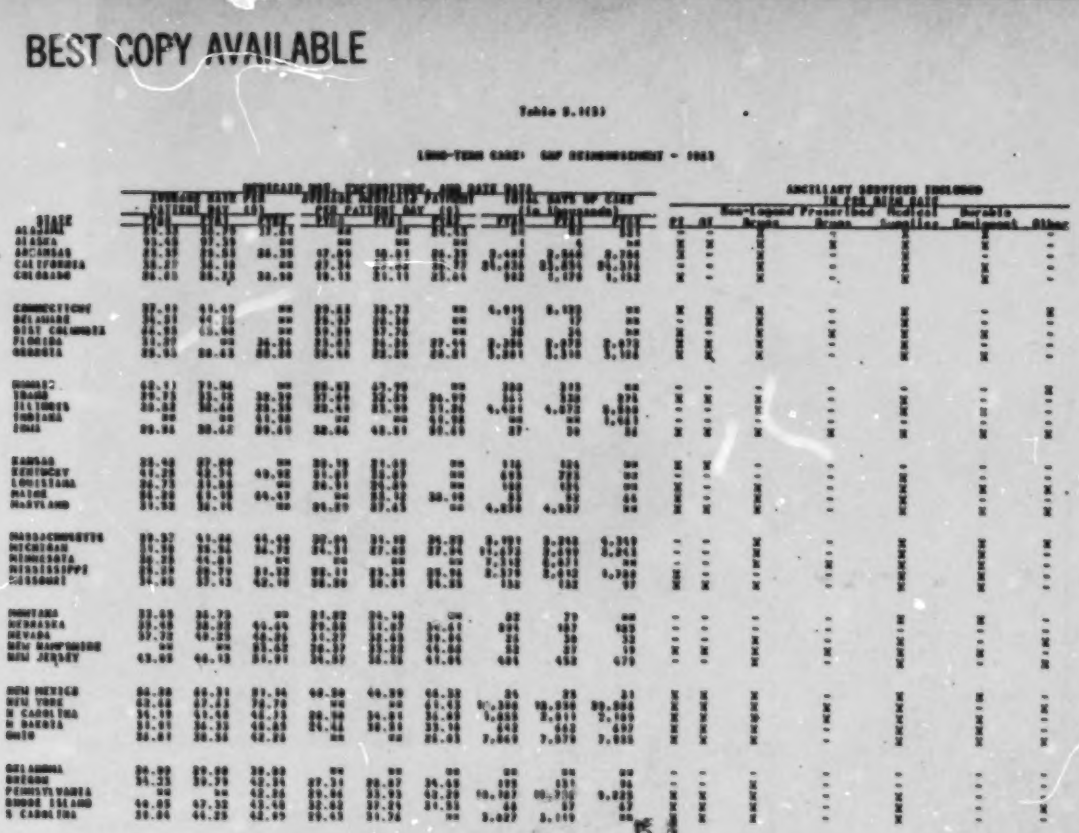

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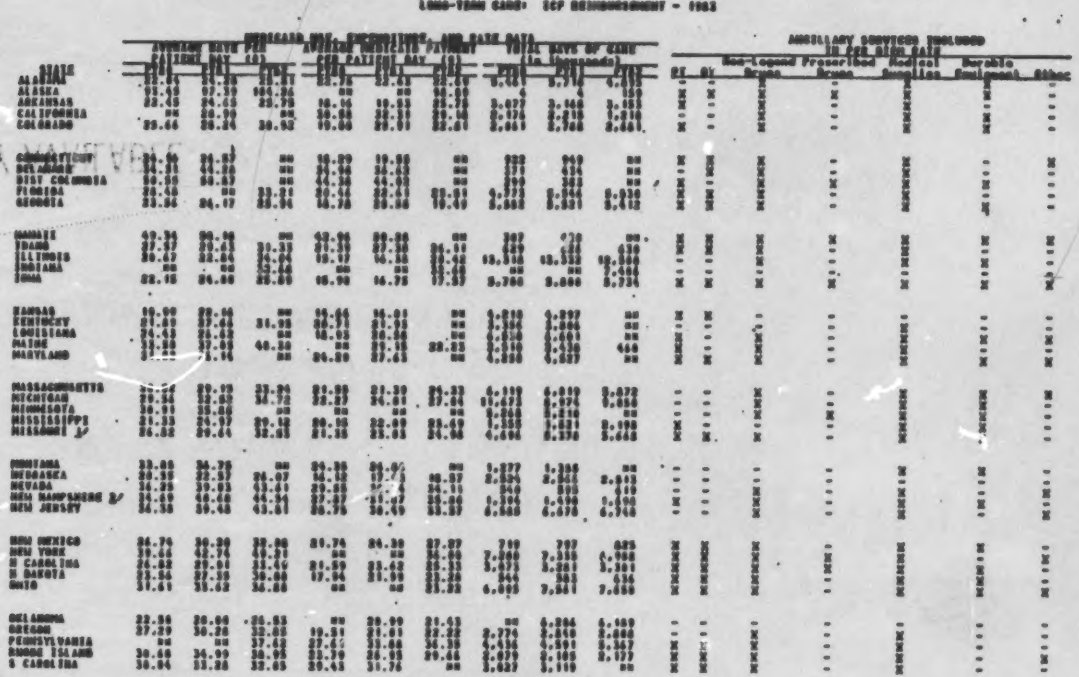

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Table 5.1(B) (Con't)

LONG-TERM CARE: ICF REIMBURSEMENT - 1985

STATE	AVERAGE RATE PER PATIENT DAY ($)			MEDICAID AND SUPPLEMENTAL (SSI) DATA: AVERAGE PAYMENT PER PATIENT DAY ($)			TOTAL DAYS OF CARE (In Thousands)			ANCILLARY SERVICES INCLUDED IN PER DIEM RATE						
	FY83	FY84	FY85	FY83	FY84	FY85	FY83	FY84	FY85	PT	OT	Non-Legend Prescribed Drugs	Medical Supplies	Durable Equipment	Other
N DAKOTA	33.43	37.01	36.68	35.36	37.63	39.68	1,250	1,301	1,437	X	X	X	X	X	X
TENNESSEE	32.58	37.03	NA	30.58	34.32	NA	6,173	6,733	NA	-	-	-	-	-	-
TEXAS	32.03	37.03	36.79	32.03	36.32	39.19	21,993	23,447	25,481	X	X	X	X	X	X
UTAH	32.03	35.26	NA	32.03	37.38	NA	719	1,076	NA	-	-	-	-	-	-
VERMONT	32.03	35.26	44.07	32.38	37.38	44.07	719	763	NA	-	-	-	-	-	-
VIRGINIA	33.38	36.38	43.66	27.34	32.24	33.78	4,143	4,448	3,488	X	X	X	X	X	X
WASHINGTON 4/	33.31	36.38	NA	NA	NA	NA	NA	NA	NA	-	-	-	-	-	-
WEST VIRGINIA 4/	37.03	38.37	37.46	NA	NA	NA	NA	NA	NA	X	X	X	X	X	X
WISCONSIN	33.00	33.00	NA	32.00	32.00	NA	6,288	7,052	NA	-	-	-	-	-	-
WYOMING	33.38	33.38	NA	32.34	32.34	NA	488	434	NA	X	X	X	X	X	X
TOTAL STATES										33	33	43	8	44	29	11
SIMPLE AVERAGE	30.86	33.49	38.98	33.16	33.31	38.68	3.881	3.978	4.537							

NA Indicates Data Not Reported or Not Available
1/ Rates are for community-based ICF-MR only.
2/ Days of care combined with ICF-MR.
3/ Days of care combined with SNF
4/ Days of care combined for all facility types.

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Table 5.1(A) (Con't)

LONG-TERM CARE: NAF REQUIREMENT - 1983

STATE	AVERAGE NAF REQUIREMENTS AND RATE DATA									ANCILLARY SERVICES INCLUDED IN PER DIEM RATE						
	Minutes Per Patient Day (A)			Hours Per Patient Day (B)			Total Days of Care (in thousands)			PT	OT	Non-Licensed Personnel	Prescribed Drugs	Medical Supplies	Durable Equipment	Other
	1981	1982	1983	1981	1982	1983	1981	1982	1983							
[illegible]	[illegible]	[illegible]	30.00	[illegible]	[illegible]	21.07	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	35.51	[illegible]	[illegible]	23.65	1,[illegible]	1,[illegible]	1,[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
TEXAS	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
UTAH	[illegible]	[illegible]	44.07	[illegible]	[illegible]	44.07	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
VERMONT	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]

Chairman HEINZ. How many States, specifically, would be $35 or under?

Dr. WILLGING. Twenty percent, according to data published by the Health Care Finance Administration last year, Senator.

Chairman HEINZ. So that would be 10 States?

Dr. WILLGING. It would be 10 States.

Chairman HEINZ. Do you have their names handy?

Dr. WILLGING. I do not have them with me, but that will be submitted as well, Mr. Chairman.

Chairman HEINZ. Very well.

Dr. WILLGING. The average, by the way, in the medicaid program, is around $45 per day.

Chairman HEINZ. Now, let me ask you just a couple of philosophical questions. But I will start with one that I think is probably more legal than philosophical.

Do you agree that Federal law states unequivocally that it is a felony to charge, solicit, accept, receive any money, donation or other consideration as a condition of admission or continued stay for a medicaid-eligible patient?

Dr. WILLGING. That is what section 1909(d) says, Mr. Chairman.

Chairman HEINZ. And you agree that that is the law?

Dr. WILLGING. That is the law.

Chairman HEINZ. It is a felony.

Dr. WILLGING. It is a felony.

Chairman HEINZ. Do you also believe that many nursing homes are therefore committing felonies on a regular basis?

Dr. WILLGING. No, I do not accept that, Mr. Chairman. I was with the Department of Health and Human Services when that law was passed in 1977. I do have some understanding of the legislative history of that provision. I know that at the time, it was designed to deal primarily with what was referred to as supplementation—essentially, the dunning of a patient, already a medicaid patient, in terms of additional resources above and beyond the medicaid payment. We are referring here to duration of stay contracts at that time. And I am not suggesting that the courts might not eventually rule that duration of stay contracts fall into that category. I am not a lawyer. But that was not what was in the minds of those, I believe, who enacted that law in 1977.

Chairman HEINZ. Dr. Willging, the law is the law, regardless of what you say or what I say was in the mind of somebody back in 1977. And let me ask you, taking into account the testimony of Mrs. Green, Attorney General Sachs—who found in the State of Maryland that contracts were rampant—do you believe that there is a widespread problem of breaking the law in the nursing home industry?

Dr. WILLGING. No, I do not, Mr. Chairman.

Chairman HEINZ. You do not?

Dr. WILLGING. No, I do not.

Chairman HEINZ. Well, then, I assume that since nursing homes are accepting medicaid patients and are not turning them out, there is no problem.

Dr. WILLGING. The question has got to be dealt with by each nursing home in each State, Mr. Chairman. Every nursing home, proprietary or nonproprietary, has got two primary responsibilities.

The first is to provide adequate care to the patient; the second is to maintain the fiscal viability of the institution. That requires in most States a certain balance as to medicaid patients and private-pay patients. That will differ in terms of each facility. Facilities have different cost structures. Facilities will be reimbursed differently, both within a given State, as well as across States. Those are decisions that each entrepreneur has got to make for himself or herself.

Chairman HEINZ. So you are saying that nursing homes should make decisions in terms of the number of medicaid recipients that they will accept, based on how much money they want to or think they need to make; is that correct?

Dr. WILLGING. I did not suggest that it is based on the amount of money that the facility thinks it wants to make.

Let me give you a piece of data, Mr. Chairman, that I think is not generally familiar; that in terms of the suggestion made by a number of witnesses before this committee, that we are talking about venal nursing home operators trying to line their pockets at the expense of the medicaid patient, that proprietary nursing homes in this country have, in terms of their patient load, an average of 57 percent indigent, mostly medicaid, patients; nonprofit have an average of 44 percent. I would suggest that if this were simply an issue related to the venality of nursing home operators, you would see those figures reversed.

Chairman HEINZ. How do you account for the fact that there is such a high proportion of medicaid patients in nursing homes? It seems to me that what you are saying is nursing homes cannot afford them; on the other hand, it seems to me that you are saying nursing homes cannot afford to be without medicaid patients, either.

Dr. WILLGING. Quite frankly, since medicaid is responsible for 55 percent of the funding in the nursing home industry, it is critical that nursing homes accept medicaid patients. My suggestion, sir, is that there is a mix that has to be carried by any nursing home so as to be able to provide the quality of care that that home wishes to provide.

Chairman HEINZ. One further question, if I may, Senator Burdick, my time is expiring.

Senator BURDICK. Please, go ahead.

Chairman HEINZ. You have mentioned, and you are quite correct, that there is a developing, if not fully-developed, shortage of nursing home beds in this country. You stated, and I do not disagree with what you said, that States have been the principal cause of these problems by restricting unduly the construction of these beds.

We have now reached the point, at least in 1982, where there appears to be a 95-percent occupancy rate of nursing home beds. That compares with a 93-percent occupancy rate in 1980, 92 percent in 1976, 91 percent in 1973, and back in 1969, a 90-percent rate. So in the last 10 years, it is accurate to say that the number of available beds at any one time has been cut in half. That is really a misleading statistic, because there are some States that are at 99.9 percent and others that are still at 90 percent.

Is it not also the case that the profitability of the nursing home industry has been improving?

Dr. WILLGING. The nursing home industry is profitable, Mr. Chairman, and I would love to find the sources referred to by Mr. Sachs and in your own statement about profitability that approaches 150 percent return within a year. I have access only to the public records submitted by the large nursing home corporations through provisions of the Securities and Exchange Commission. The pretax—I emphasize, pretax—net income of those chains ranges from 1.5 percent to 7 or 8 percent.

Chairman HEINZ. Of what?

Dr. WILLGING. Of the large corporations—the Beverlys, the Hillhavens, the Manor Cares——

Chairman HEINZ. No; you said 1.5 percent to 8 percent, and I am saying that is an interesting percentage, but what is it a percentage of?

Dr. WILLGING. It is the net income that is the post-expense income that is available to the facility as profit.

Chairman HEINZ. As a percent of gross income?

Dr. WILLGING. Correct.

Chairman HEINZ. By the way, you may be aware that in the supermarket industry—which at one point, I had a tangential relationship to, having sold to them for many years some branded, very high-quality food products—that any food chain that has a return on sales of 5 percent is probably in the top 5 percent of profitable businesses in the entire world.

Dr. WILLGING. I am aware of that——

Chairman HEINZ. So percent return on sales is not a reliable measure of return on investment or return on equity.

Dr. WILLGING. I am aware of those figures, Mr. Chairman. I am aware, as you are also, that the supermarket industry is well-known for having the narrowest margins in that regard of almost any other industry in the country.

Chairman HEINZ. And the highest return on equity periodically.

Dr. WILLGING. What I am suggesting, Mr. Chairman, is that what we are looking at is an industry which by its design is an investor-oriented industry. Eighty percent of nursing homes in this country are investor oriented, ranging from a single owner, the so-called mom-and-pop nursing home, to the larger chains. For it to continue to grow so as to meet the needs of this elderly population, the demographic tide that is hitting us, there has to be some reasonable profit or investment will dry up. I think we all recognize that. Now, what the level of profit is, I will not quibble about, but it has got to be there.

Chairman HEINZ. Let's not quibble about it, and let us see if we cannot get some facts on the table, because my question to you was, is it or is it not true that the profitability of the nursing home industry has been improving over the last several years.

Dr. WILLGING. I do not know whether it has been improving. Let us just say that the nursing home industry can be profitable, depending upon the State.

Chairman HEINZ. Do you think that if indeed it were improving, that it would be material to this discussion?

Dr. WILLGING. I would have to ask you how you think that would be material.

Chairman HEINZ. Well, as I understand your argument, it is that nursing homes have to have a certain mix of private-pay patients in order to afford to take medicaid patients. The implication is that medicaid patients are somehow unprofitable for facilities. Here, if it were in fact true that nursing homes are increasing their profitability, it would seem to me that the case that you implicitly make, which is that nursing homes should be free to discriminate against nursing home patients would be simply a rationalization based on greed

Dr. WILLGING. I would suggest, Mr. Chairman, using perhaps different words than you have, that in any individual nursing home situation, that its profitability will in fact be a factor in terms of how it judges the mix that is required for continued fiscal solvency. I would tend not to use the word "greed" because I do not think that is, in fact, germane. We are talking about an industry of some 20,000 homes. There are indeed providers who we would just as soon not have in that industry. But I would suggest that the vast proportion of the industry is not, in fact, venal; is not operating on the basis of greed or avarice, and I would dispute the contention that they are.

Chairman HEINZ. What would you say about the instance of Mrs. Green?

Dr. WILLGING. I think you will find cases, given the fact that we are talking about 20,000 nursing homes, you will find cases where the attitude toward the patient leaves a great amount to be desired. I am not going to sit here and attempt to defend the practices of each of those 20,000 nursing homes.

Chairman HEINZ. Does the American Health Care Association have a responsibility to advise the nursing homes that are members what the law is, and if they have policies that are contrary to law, that they are guilty of a felonious practice?

Dr. WILLGING. We indeed have a responsibility, and we have submitted to the Department of Health and Human Services a request for its own legal interpretation of 1909(d) and whether it did, in fact, apply to duration of stay contracts.

Chairman HEINZ. When did you do that?

Dr. WILLGING. This was done about a year or so ago, sir.

Chairman HEINZ. You have received no answer?

Dr. WILLGING. We have received no answer.

Chairman HEINZ. Well, maybe we can get you an answer on that, but you yourself seem to believe that a plain, English language reading of the statute means that discrimination against medicaid patients is illegal. Why can't you advise your membership of that, or have you done so?

Dr. WILLGING. Against medicaid patients, Mr. Chairman. Let me remind you again that these contracts when initiated are not between the facility and a medicaid patient; they are between the facility and a private-pay patient. And that is, I think, one of the sources of legal contention in terms of that issue.

Let me suggest, though, Mr. Chairman, that for the sake of argument, let us say that such contracts are illegal. Let us say that such contracts should be and would be, through enforcement, pro-

hibited. That deals once again with a symptom of the problem, Mr. Chairman; it does not deal with the root causes of the problem.

What we would conceivably see, if we continue to couple the problems of arbitrary constraints over supply, and inadequate reimbursement in many States, what recourse then does the nursing home administrator have? To not only, as you use the term, discriminate against medicaid patients, but to discriminate against the near-medicaid patient as well, so that the nursing home, where it can do that, in effect is exclusively limited to a private-pay market which has no chance of becoming medicaid. I would hope that would not happen. But I think that is one of the likely consequences of continuing to deal with the symptoms, rather than with the cause, of the problem.

Chairman HEINZ. If the symptom indeed is in some States inadequate reimbursement, but if we also agree that there are mixed motivations in nursing home operators, and that there are some who—although you may say it is the rare few—who would be tempted to take more profitable private-pay patients rather than less profitable or, as you perhaps might say, at least in some instances, inadequately-reimbursed medicaid patients, is not the answer twofold—one, for the Government to insist on nondiscrimination between the two, so that those people who simply want to make more money—whatever your concept of a reasonable profit is is subjective judgment—but who simply want to gain the system to make the maximum number of bucks off it—it seems to me we have no alternative but to enforce the law, to prevent that, and it seems to me your association, rather than they did in California as lobbying against an increase in the number of nursing home beds, should be lobbying where it is justified for more beds, and second, for proper reimbursement from State legislatures.

Dr. WILLGING. I would couple a third point, yes. I would say that a solution to the problem is to let the market begin to take care of the problem——

Chairman HEINZ. But wouldn't you also agree that if what I have said is true at the State level, that it is also true that we should enforce with total vigor the Federal law?

Dr. WILLGING. As the Federal law is ultimately in the courts determined to be, I would agree, Mr. Chairman. Let me also suggest, though, that we have got to in this country—and you know this better than anyone in this town, Senator—we have got to deal with a much larger issue.

We are talking about a demographic tide, 2.2 million Americans today over the age of 85, some 8 million over the age of 85 within 30 or 40 years, States continuing to be looked upon as the primary source of funding, States who are wondering whether they can keep up with that—and no alternative in the offing as to how we begin to bring together the resources to take care of those elderly Americans.

I can sympathize, although not agree, with States as they look at that problem of saying there is no way we can provide the kind of reimbursement required; there is no way we can allow the beds to be built that should be built in this State. Unless we begin to find in this country a way of marshalling the resources to deal with the needs of America's elderly, we are going to continue to have these

problems. We will continue to have these hearings. The problem will not go away simply by legislating away the symptoms.

Chairman HEINZ. Dr. Willging, I agree with you on that, but the problem of Mrs. Green and the others who testified today is also here and now, and we have to deal with both problems.

Senator Burdick, I thank you very much for permitting me to continue my line of questioning.

Senator BURDICK. Welcome to the committee, Dr. Willging.

Dr. WILLGING. Thank you.

Senator BURDICK. I notice on page 1, you state that, "At least 16 States have imposed some form of moratorium on the construction of new nursing home beds," and you list the various States.

Now, the implication is clear that they are not building these homes, because it is not profitable; is that correct?

Dr. WILLGING. The State is preventing the building of these homes, Senator Burdick. What the State is saying in those 16 States, either through explicit statute or administrative rule, or informally, by simply not listening to applications for construction within the certificate of need process—States are saying for whatever period of time, they will not allow any more homes to be built in this State. Sixteen States essentially have said, "No more nursing homes will be built in this State."

Senator BURDICK. Well, I submit that there is another reason for not building more homes. You are well aware that increased knowledge of illnesses, better care, have shortened hospital stays. I remember when an appendectomy would take about 3 to 4 weeks of hospitalization. Now an appendectomy takes about 3 days. So it goes with a lot of the cases.

So, we have found ourselves in my country with an excess of hospital beds. To alleviate the situation, a lot of these hospitals set aside a part of the hospital for long-term care, and they have used up the space that way.

I am just wondering if a lot of these States did not find the same situation, and with their excess capacity in the hospitals, they just turned it over to long-term care. The Veterans' Administration did the same thing.

So I wonder, just to say that these care facilities are not being built because of profitability is not exactly correct.

Dr. WILLGING. Well, I think they are not being built, Senator, because the States recognize that if they are built, at least half of them would, by definition, be filled by medicaid patients, and the States are trying to save that incursion into the State budget.

In terms of the use of excess capacity in the hospital arena and moving it into the long-term care arena, I think that is an issue that is worthy of scrutiny. I think, though, that we should also recognize, be it in terms of distinct parts in hospitals or swing beds in hospitals, that the average length of stay of a nursing home patient is 1½ to 2½ years. You cannot in the hospital setting assume the same type of care—the absence of dining rooms, the absence of recreation facilities, the absence of the sorts of things that make up a nursing home—that those will necessarily be provided in the hospital setting. We do not oppose the concept of swing beds, we do not oppose the concept of distinct parts. What we are suggesting is let us remember that the nursing home patient is not the same pa-

tient as an acute care patient, and let us deal with the patient according to the patient's needs, and not the needs of the facility.

Senator BURDICK. Well, of course, you know that in the hospitals, they maintain quite a separation in the two classes, and in hospitals, to take the long-term care users is almost tantamount to having a separate facility, in some cases.

But I just wanted to indicate that, that the mere fact that a lot of these States are not building long-term care facilities is that they do have long-term care facilities in this type of operation.

Thank you, Mr. Chairman.

Chairman HEINZ. Senator Burdick, thank you very much.

Dr. Willging, two last questions. I think they are fairly brief. Congress has assured providers a medicaid rate adequate for an efficient operator. That is the law of the land. That is part of Federal statute. Have your State affiliates or chapters ever sued the States, which are the final arbiters of medicaid rates, to achieve a more equitable enforcement, and if so, what has happened?

Dr. WILLGING. The association itself has not sued the States. In many of our State affiliates, there has been legal action taken, and indeed, in many of the individual facilities with, as is always the case in the judicial process, varying degrees of success.

But yes, there have been within the last year or two, a number—and I can try to develop that and submit it to the committee, Mr. Chairman—a number of successful actions taken against States in terms of the arbitrariness of the rates established.

Chairman HEINZ. We would appreciate receiving those.

Second, do you know if in those States, any of those 10 or 15 States where medicaid reimbursement may be inadequate, if any facilities have closed because of alleged inadequate reimbursement for medicaid?

[Subsequent to the hearing, Dr. Willging submitted the following material:]

A H C A M E M O R A N D U M

TO: The Honorable John Heinz, Chairman
Senate Special Committee on Aging

FROM: Paul Willging
Deputy Executive Vice President

SUBJECT: Recent Litigation on State Medicaid Nursing Home Reimbursement Rates

DATE: October 26, 1984

As I agreed during my testimony before the Committee in its October 1, 1984 hearing on "Discrimination Against the Poor and Disabled in Nursing Homes," following is information regarding selected recent litigation regarding reimbursement rates by nursing homes and state associations against state Medicaid agencies:

1. Illinois Health Care Association v. Quern, ____ F. Supp. ___, No. 77-C-1109 (N.D. Ill. Jan. 31, 1983), reported in CCH Medicare & Medicaid Guide at Para. 32,296 (1983-1 Transfer Binder).

   Issues: Rate cuts without notice and based solely on budgetary consideration.

   Outcome: Preliminary injunction granted

2. Ash Grove Nursing Homes, Inc. v. Missouri Department of Social Services, ___ F. Supp. ___, No. 83-4023-CV-C-5 (W.D. Mo. Feb. 11, 1983).

   Issue: Pro rata rate reductions, without notice, in compliance with governor's order to reduce expenditures.

   Outcome: Permanent injunction issued.

3. Bolivar Nursing Home v. Missouri Department of Social Services, No. CV 183-76 CC (19th Jud. Cir. Mo. Mar. 18, 1983).

   Issue: New reimbursement methodology using cost centers with different percentile ceilings for each. Methodology not based on adequate data and analysis.

   Outcome: Permanent injunction issued.

4. The Hillhaven Corp. v. Wisconsin Department of Health and Social Services, 733 F.2d 1224 (7th Cir. 1984).

   Issue: Rate freeze.

   Outcome: Preliminary injunction issued.

5. Nebraska Health Care Association, Inc. v. Dunning, 575 F. Supp. 176 (D. Neb. 1983).

   Issue: Limitation, unrelated to actual costs, on reimbursement rate increases and pro rata cuts in reimbursement rates due to insufficient available funds.

   Outcome: Permanent injunction issued.

6. Cascade County Convalescent Nursing Home v. Department of Social and Rehabilitation Services, Cause No. CDV-83-867 (Dist. Ct. 8th Jud. Dist. Mont. Aug. 30, 1984).

   Issue: Reduction in rate adjustment factors in response to insufficient legislative appropriations.

   Outcome: Preliminary injunction issued.

7. United Nursing Homes, Inc. v. McNutt, 669 P.2d 476 (Wash. Ct. App. 1983).

   Issue: Reimbursement rates below reasonable and allowable costs.

   Outcome: Reimbursement plan (state regulations) found invalid and facilities awarded damages based on court ordered formula.

Thank you for the opportunity to present this information.

PW/RE:ac

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Dr. WILLGING. I would tend to doubt if any of them have closed. I think there are two other options that are undertaken by a facility before it closes. One is to reexamine its mix of medicaid and private-pay patients, as I have suggested. Second, unfortunately, is to begin to try to maintain fiscal viability, but to do it in terms of the resources put into the care provided. What worries me is that the care which a facility might like to provide is not possible, given those rates, and what is provided is no more than the minimum required by Federal and State legislation. Federal and State legislation does not require anything more than the minimum.

In the example of the State of Maryland—by the way, the State of Maryland does not have these kinds of problems, because the State of Maryland, one, does allow through the certificate of need program, additional construction, and has a reimbursement program that I would commend to this committee in that it does look at the needs of the patient, and they put that system in within the last year or two, and they have found that the heavier care patient is now being accepted by facilities in the State of Maryland.

Take away some of those constraints on reimbursement and on supply, as Maryland has, and you will find a much more enviable situation as far as the care provided.

Chairman HEINZ. Finally, in your experience, are the problems that you have described regarding reimbursement and shortage of beds and State limitations on beds—do you see those problems getting worse, or do you see them curing themselves by virtue of the individual initiative at the State level?

Dr. WILLGING. As long, Mr. Chairman, as there is not an alternative funding source for a patient—and I do not mean his or her own private funds—as long as there is no alternative to the Medicaid Program, the program of last resort, I think those problems will get more serious. That is why my association strongly supports the concept that you have suggested, independent living insurance, so as to provide alternative and different funding sources, to take some of the burden off the State medicaid programs. They cannot alone be expected to deal with this rising tide of elderly Americans who are going to need care, and I think that, quite frankly, is the solution we have to rally around in this town over the next 4 or 5 years.

Chairman HEINZ. What we have learned at this hearing today, I think, is that there are a variety of Federal laws on the books, two of which—involving the patient's bill of rights and second, involving the 1977 amendments—that are very clear that it is illegal for nursing homes to charge, solicit, accept, or receive money, donation, or other consideration as a condition of admission for continued stay in a medicaid-certified nursing home.

We have also heard today from a number of people who fell victim to nursing homes that, at least in my judgment, were not only committing a very immoral act, I think, but they were committing an illegal act, a felony under Federal law, punishable by a $25,000 fine and/or 5 years in prison or both.

What advice do you have to our other witnesses on the beneficiary panel—Mrs. Green or her now deceased mother, or the other witnesses—when they are told to sign a duration of stay contract, or when their parent becomes medicaid-eligible, and the nursing

home says, "We are moving your mother today." What advice do you have for those people?

Dr. WILLGING. I certainly would not suggest, given the fact that we are dealing with individuals who do not necessarily have the resources of the upper middle class, I would not suggest that they immediately retain legal counsel as was suggested by the attorney general of Maryland.

I would suggest, however, that they immediately seek the advice of a group of individuals in the States that our association supports, and indeed, would suggest be strengthened—the ombudsman program within the States. There are people who do know the situation within each particular State; they do know the laws and the regulations as pertain in that State. And I would strongly urge that they be used by recipients of the service, by parents, by families.

Chairman HEINZ. So, how would Mrs. Green find an ombudsman in the State of California among the 40 million people out there? How would she do that?

Dr. WILLGING. Well, the ombudsman is a State official which can, I gather, through a variety of mechanisms, be identified. In fact, were Mrs. Green to even contact the State nursing home association, she would be provided with the name and telephone number of the ombudsman in that State.

Chairman HEINZ. And in New York?

Dr. WILLGING. The same.

Chairman HEINZ. And in any of the other States, just call up the State nursing home association?

Dr. WILLGING. If indeed the issue is getting the name and number of the ombudsman.

Chairman HEINZ. And do you believe that all the nursing home associations will provide that?

Dr. WILLGING. I do not know if they do all now provide it. I think it is something I would suggest to my affiliated State associations.

Chairman HEINZ. Let us assume for the moment that they just might not have it immediately available, in the same way as they do not have these regulations immediately available to them—then, what?

Dr. WILLGING. Well, you are asking me to hypothesize as to where one could go for information.

Chairman HEINZ. Well, let me go one step further. Let me give you for the moment a 70-year-old parent who is in need of nursing home care, and their life savings have been used up by 6 months in the nursing home. You yourself have done everything you can, and you have augmented the payments with what life savings you have been able to accumulate, and they are now gone, so Lord help you if you ever have to go in a nursing home. You are not even able to be a private-pay patient, because that money is already gone. And you are desperate. The nursing home says, "Well, we are turning your mother out this morning." It is 8:06 in the morning. "Please pick up her linen, and so forth." And the nursing home association does not have the information.

What would you do? What would you advise someone like that to do?

Dr. WILLGING. Well, I would advise a variety of things. If that individual feels that discrimination has occurred, that it is illegal, and if indeed it is not the ombudsman that can deal with that, there are in fact the State officials, the departments of health and public welfare within the States; there are one's elected officials both at the State level as well as the Federal level——

Chairman HEINZ. There are lots of people in government you can talk to. I talk to them all the time, and it does not do me any good, either. What you have advised is to talk to everybody you can, but——

Dr. WILLGING. What are you suggesting, Mr. Chairman, a "hot line" of some kind?

Chairman HEINZ. I am asking you as a representative of this industry, which you claim does not discriminate and does not as a general practice violate Federal law, what a person, a poor person or his children, who may be 55 or 60 themselves, what they should do if they find, one of these according to you, rare instances of discrimination against medicaid patients.

What you have advised is, well, call the ombudsman. And I am saying that if you call the ombudsman at 8:06 in the morning, even if they are there, they are going to say, "Well, we will look into it." Meanwhile, your mother is cast out on the street, or sent down the river to the next nursing home.

And you are saying, well, call somebody else.

Dr. WILLGING. I have given you a list of at least a half dozen different sources that one could deal with. We could continue for the rest of the day——

Chairman HEINZ. Well, here is my point. Do any of those people you have recommended have the power to stop what is an illegal action?

Dr. WILLGING. Only the law enforcement agencies in this country and the courts have the power to stop what is an illegal action.

Chairman HEINZ. But yet, you have said, "Do not go to a lawyer."

Dr. WILLGING. In that case, where there is no other recourse, and an individual is concerned about the legality of an action, in that case, yes, I would go to a lawyer.

I am suggesting and suggested, Mr. Chairman, that in terms of general issues regarding nursing home practices, that there is the concept of the ombudsman. I was not suggesting that in a case of dire emergency, where in fact it is contended that an illegal act has been committed, that one should not go to a lawyer. I apologize if, in fact, you misconstrued my comments in that regard.

Chairman HEINZ. One last question. Do you believe that the Federal Government should fully enforce the statute that makes it a felony to charge, solicit, accept, receive money, donation, or other consideration for admission or continued stay?

Dr. WILLGING. I believe the Federal Government should fully enforce any statute on the books, Mr. Chairman.

Chairman HEINZ. I thank you.

The hearing is adjourned.

[Whereupon, at 12 o'clock, the committee was adjourned.]

APPENDIXES

Appendix 1

SUMMARY of COMMITTEE FINDINGS:

PREVALENCE OF DISCRIMINATORY PRACTICES BY NURSING HOMES

- National Summary of State Nursing Home Ombudsman Reports for United States, Fiscal Year 1982 reported that discrimination against Medicaid recipients or potential Medicaid recipients in admissions, room assignments, and/or discharges, was identified as a major problem by 21 States, the fourth most frequently mentioned problem out of 74 named (States citing this problem were: CA, CO, DC, FL, GA, HI, KY, MD, ME, MI, MT, NH, NJ, NY, OH, PA, RI, TN, VA, WA, WI).

- The 1982 Summary results represent a substantial increase since the 1981 National Summary of State Ombudsman Reports, which indicated that 16 States reported discriminatory practices as a major problem (ranking 14th out of 69 named, and named by the following States: CA, CT, DC, FL, GA, HI, ME, MI, MN, NJ, NY, OH, PA, RI, VT, WA).

- A General Accounting Office report in October of 1983 suggests that discrimination on the basis of handicap is a prevalent feature of nursing home admissions policies. GAO summarized 11 studies conducted since 1979, all indicating that a substantial number of hospital patients -- as many as 9 million patient days per year -- were medically certified as needing nursing home care but were "backed-up" in hospital beds because they were Medicaid eligible and had heavier than average care needs. GAO concluded "(t)he coexistence of empty nursing home beds and backup patients needing them suggests that some nursing homes, knowing that their beds will soon be filled, have an incentive to wait the short period of time it may take to admit a more economically desireable patient".

- 66% of the facilities in Macomb County, Michigan, and 26% of facilities in Oakland County required private pay periods ranging in length from 6 to 24 months in length.

- 56% of facilities in one suburban community outside of Boston required private payments for a fixed period.

- New Jersey Task Force estimates 80% of facilities require fixed period of private pay for up to 3 years. The Task Force estimated some 1800 currently Medicaid eligible patients in that State's nursing homes are being paid for at private rates, usually by relatives. Thus, the families of nursing home residents were forced to pay some $36 million annually for services taxes would have covered.

- The Maine Committee on Aging found 6 of 22 facilities surveyed (27%) required private pay periods before they would accept Medicaid payments.

- According to analysis by the State Medicaid agency in Maryland, in July 1982 44 of 179 (31%) of certified facilities required private pay periods. In September, 1984, two years after the Attorney General informed providers of the illegality of such contracts, 24 of 185 homes (14%) still require such private pay periods.

- The City of Berkeley, California, investigated discriminatory practices in 1983 and found:
  - evidence of illegal evictions of persons who converted to Medicaid after running out of money

* that to gain entry to a facility in that City, a person would need to have $36,000 to $48,000 to spend before they could expect the facility to admit them for care
* of 5 certified facilities, none would accept Medicaid payment for a newly admitted patient
* only 14% of nursing home residents in the City were paid for by Medicaid, compared to 66% in the surrounding area and 70% in the State of California
* due to a lack of enforcement by State and Federal officials, the City of Berkeley passed an ordinance to ban Medicaid discrimination within the City limits.

• The Committee has learned of more than 50 specific illegal admissions contracts which require in writing private pay periods, or other consideration as a condition of admission, and/or eviction when a person converts to Medicaid.

• Case histories of individual beneficiaries who have experienced discriminatory practices by nursing home providers in seven States indicate these practices generally take the form of private pay duration of stay contracts and occasionally involve eviction.

• The Kentucky Ombudsman estimates that 25%+ of facilities in that State require private pay duraion of stay contracts. A community hospital reported that, during a sample period in the third quarter of 1982, a single proprietary nursing home refused or delayed admission for 8 heavy care patients, and 2 additional Medicaid eligible patients, while 5 heavy care but private paying patients were promptly admitted during the same time period.

• A Georgia ombudsman estimates that 12% of Atlanta area facilities require periods of private pay in their written contracts, with many more making such demands orally. Rural areas of the State may have a greater problem. The ombudsman reported that nursing homes in the State are with increasing frequency evicting patients who convert to Medicaid from some other form of payment.

• A Pennsylvania nursing home ombudsman estimated that 80% of the nursing homes in the Philadelphia area use private pay duration of stay contracts or discriminate in other ways, saying that private pay "agreements" are "not just prevalent, but customary".

• The Florida State Ombudsman's report to the legislature for 1984 cites newspaper accounts and complaints relating discriminatory practices by nursing homes, including private pay contracts. A patient advocate in St. Petersburg reported that providers have continued to demand private pay requirements orally, rather than in writing, since the illegality of the practice became known.

• The Washington State Ombudsman reported that many hospital discharge planners are advising indigent patients and their families to pool their money, so they are able to pay privately for at least a while, in order to make themselves "more attractive" to nursing homes. One discharge planner told the Ombudsman "we literally have to sell Medicaid patients to nursing homes".

Appendix 2

SURVEY OF NURSING HOME PROFITS AND MEDICAID CENSUS

# Facilities	% Medicaid Census	Mean (average) % Return on Equity	Median % Return on Equity
39	0 - 10	154%	32%
17	11 - 20	111	48
20	21 - 30	37	33
33	31 - 40	109	30
31	41 - 50	53	40
43	51 - 60	68	27
106	61 - 70	42	26
163	71 - 80	52	25
183	81 - 90	70	22
65	91+	58	19
Total: 700			

NOTES:

1. Source: FY 83-84 data from California Health Facilities Commission.

2. Median values minimize very high ROE figures resulting from leasing arrangements, etc., and therefore provide a more conservative representation of nursing home profitability.

3. Sample studied includes reporting proprietary (for profit) Skilled Nursing Facilities with reliable data in California for the period indicated.

4. The Medicaid reimbursement rate for Skilled Nursing Facilities in California for the year 1982 was approximately $39 per patient day. It is estimated that 30 States paid higher rates per patient day for SNF care, with the national average being about $42 ppd.

Appendix 3

ILLEGAL AND QUESTIONABLE CLAUSES FROM NURSING HOME ADMISSION AGREEMENTS

Admission Agreement from California

ADMISSION POLICY

IT IS THE POLICY OF THIS FACILITY NOT TO DISCRIMINATE OR REFUSE ADMISSION TO ANY PERSON BECAUSE OF RACE, COLOR, SEX, NATIONAL ORIGIN, OR CREED.

GOVERNMENTAL PROGRAMS

OUR FACILITY ACCEPTS PATIENTS ELIGIBLE FOR BENEFITS UNDER THE FEDERAL MEDICARE PROGRAM.

HOWEVER, WE NO LONGER ARE ACCEPTING PATIENTS UNDER THE STATE MEDI-CAL PROGRAM BECAUSE THE REIMBURSEMENT RATE IS INSUFFICIENT TO COVER OUR COST OF CARE.

WE REGRET THAT IF A PATIENT TRANSFERS FROM PRIVATE STATUS TO THE MEDI-CAL PROGRAM, THE PATIENT WOULD BE REQUIRED TO TRANSFER TO ANOTHER FACILITY.

Admission Agreement from California

ADDENDUM TO
ADMISSION AGREEMENT & CONSENT FOR TREATMENT

1. The patient acknowledges that the facility does not seek, encourage or admit Medi-Cal patients generally. Patient recognizes and agrees with facility's policy to provide services to Medi-Cal patients only as a convenience to its patients who have been in the facility for at least twelve months. Patient wants the benefit of such policy and therefore agrees to leave the facility upon applying for or obtaining Medi-Cal benefits, both for the welfare of the patients and in recognition of the partial nonpayment of his account when payment is made at the Medi-Cal rate. Patient further understands that but for his or her agreement to this provision, facility would not admit patient.

2. Persons receiving Medi-Cal benefits must make this information available to the hospital in writing at the time of the application for admission. Failure to do so will result in the patient, his agent or representative being liable for the difference between the basic rate and the Medi-Cal rate until the first day of the month following official notification of the patient's Medi-Cal status as liquidated damages for the injuries suffered by the facility by the patient's breach. In addition, the patient agrees to leave upon the facility's request, recognizing that it is the facility's right to restrict the admission of Medi-Cal patients and that its right to do so is inhibited by the patient's failure to indicate his or her Medi-Cal or welfare status. Should the patient leave immediately upon official notification of Medi-Cal status, facility will reimburse the difference between the Medi-Cal rate and the basic rate.

3. If there is any change in welfare status (eligibility, liability, etc.), I/we agree to make this information immediately available to the hospital. All Medi-Cal identification cards must be turned in to the hospital business office as soon as possible as receipt.

DATED: _____ PATIENT'S SIGNATURE _____

GUARANTOR'S SIGNATURE _____

BEST COPY AVAILABLE

Admission Agreement from Maryland

AGREEMENT OF ADMISSION

This Admission Agreement, made on and as of this _____ day of _____, 19___, by and among _____

_____ (the "Home") and _____
(Nursing and Convalescent Center) (Name of Legally Responsible Person)

(the "Responsible Party") and providing for the terms and conditions under which _____
(Name of Patient)

(the "Patient") shall be admitted to the Home. In consideration of the mutual convenants contained herein and other good and valuable consideration, the receipt of which is hereby acknowledged, the parties hereto agree as follows:

A. Services to be Provided by the Home. The Home agrees:

(1) To furnish its regular 24-hour nursing care, personal care as may be required for the health, safety, comfort, and well-being of the Patient, and incidental services and accomodations including laundered linens, bedding, and room and board as required by relevant State and Federal laws and regulations.

(2) To obtain the services of a licensed physician of the Patient's choice or the services of another physician if a personal physician has not been designated or is not available, as well as such medications or medical procedures as ordered by the physician.

(3) To arrange for transfer of the Patient to a hospital or clinic when this is ordered by the attending physician, or in the case of an emergency.

(4) To arrange, at the expense of the Responsible Party, should the Patient expire, for the removal of the deceased to the _____
_____ Funeral Home or other appropriate Funeral Home, if the Responsible Party cannot be reached.

(5) NOTE: This facility does not have any direct or indirect financial interest in any of the ancillary services provided.

B. Agreement of the Responsible Party and Patient. The Responsible Party and the Patient agree:

(1) In the event that the patient is to be admitted to the Home as a private pay patient (i.e. such Patient's admission is not to be covered under Title XVIII, the ["Medicare Program"] or Title XIX, the ["Medicaid Program"], of 42 U.S.C.A. Sec. 1395 and 1396), to pay to the Home, in consideration for the services to be provided by the Home as set forth in Paragraph A above, the amount of $_____ per _____.

(a) Patients that are determined to be acute chronic care, will be charged our current acute chronic care rate.

(2) In the event that the admission is to be covered under the Medicaid Program and/or the Medicare Program, the Home shall be entitled to collect in respect of such Patient, the maximum amount allowable under the applicable program from time to time in effect for patients receiving the level of care for which the patient is certified, subject to the provisions of sub paragraph 3, below, relating to the obligation of the Patient and the Responsible Party to pay over to the Home any source monies paid directly to the Patient.

(3) To pay to the Home, promptly upon receipt of same, any and all amounts paid directly to the Patient or to the Responsible Party on behalf of the Patient by any governmental agency or disbursing authority (such as Social Security, V.A., Railroad Retirement, and Civil Service Annuities) and/or any other resource as determined by the Department of Social Services, if the effect of such direct payment has been to reduce the amount of any governmental payment under B(2) above paid to the Home in respect of the Patient for the same fiscal period, so as to ensure that the total amount of payments received by the Home in respect of the Patient equal the rate set forth in the Home's contract with said governmental agency.

(4) To pay all other charges for which there is no third party contract between the Home, the insurer and the Patient.

(5) To pay one month's charge in advance upon admission as a private patient and to promptly pay all statements in full when received. The advance payment requirement shall not apply in the case of a Patient's residence covered under the Medicare Program or the Medicaid Program.

(6) To pay all charges incurred in the care and services provided to the Patient in the Home, except as covered under the Medicare Program or the Medicaid Program as delineated below:

(a) Physician's services and consultations, medical procedures and examinations and therapeutic services as ordered by the physician.

(b) Medical supplies, drugs, biologicals, eyeglasses, hearing aids, dentures, medical appliances and other medical devices.

(c) Personal items and services such as telephone calls, clothing, personal laundry, barbers, and beauticians, toiletries and sundries which are not normally provided as part of nursing care.

(7) To pay all charges for the care and services which are provided to the patient outside of the Home, except as covered under the Medicare Program or the Medicaid Program. These charges include:

(a) Clinic visits or hospitalization of the patient, if it becomes necessary.

(b) Clinical and laboratory tests and emergency treatments provided to the Patient while away from the home.

(c) Ambulance and transportation expenses in the event they are incurred.

(8) To provide such personal effects and services as needed or desired by the Patient which are not the responsibility of the Home and to be responsible for all valuables, money, appliances, and other personal property left in the possession of the Patient while at the Home. The Home, at the Patient's request, shall provide for safekeeping of Patient funds, and will provide periodic accounting to the Patient.

C. Additional Covenants of the Parties. The parties hereto further agree and understand as follows:

(1) In the event that the Patient is desirous of being certified to receive payments through the applicable State Medicaid Program, the Home, the Patient and the Responsible Party shall give full cooperation and supply all required information to such State so as to aid in the prompt determination of the eligibility of the Patient. If it is determined that the Patient does not qualify for the State Medicaid Program, the Patient and Responsible Party shall be liable for all charges incurred by the Patient at the then applicable private rate up to the date of such determination.

(2) If the admission of the Patient is made on the understanding that all or part of the care will be paid by the Medicare Program or some form of medical insurance and such application for payment is rejected after application for same is made then the Responsible Party and the Patient jointly and severally agree to indemnify the Home against all charges incurred in the care of the Patient and for all services rendered to Patient. These charges are to be paid immediately upon notification. If such charges are not paid within (10) days from the invoice date, the Home in consultation with the Patient or Responsible Party, shall attempt to resolve the non-payment status and if not resolved, the Home will issue a thirty (30) day notice to remove the Patient from the Home. All accounts shall be considered past due after thirty (30) days and a one and one-half percent (1½%) monthly service charge will be added thereafter, plus any collection fees incurred.

It is agreed by the Responsible Party that our contract for the private pay patient is for one (1) year at the given per diem rate.

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Admission Agreement from Michigan

NOTE: STORAGE OF RESIDENT EFFECTS: The personal effects of residents, including furniture, will be stored up to 10 days after a resident/patient surrenders their room or bed without charge. Thereafter, a Storage Charge of up to $1.00 per day will be charged until removed from the Facility.

NOTE: Because of inadequate reimbursement currently under the Medicaid Program, Senior Citizens Fund makes no guarantees, expressed or implied, that a patient may continue in residence at Community Nursing Home under Medicaid. Such provision must be on a quota basis, and at the sole discretion of Senior Citizens Fund.

_____
(for) Applicant
By_____

ADDENDUM "A"

I understand and agree to the above contract, and hereby agree to pay on behalf of the herein named applicant, the per diem rate applicable for at least three years after admission, or until removal from the Home, whichever comes first. It is also understood that the rates now agreed upon may change, depending on the measure of care and services required, or as may be determined by Senior Citizens Fund, upon seven days notice.

I further agree that in event the herein named applicant is requested to remove from the Home, I will arrange for the removal of the patient in accordance with said notice.

(Signed)_____

Address_____
(Street)

_____
(City) (State) (Zip)

Relationship to Patient_____ Date_____

(For Office Use)

Admittance Date _____

For S.C.F. __ _____

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Admission Agreement from Michigan

The following contractual terms apply to the reimbursement sources indicated as applicable in the attached Data Sheet:

Medicare. If this reimbursement source is applicable, the Patient and Responsible Party warrant and represent that at the time of admission the Patient is eligible to receive skilled nursing services in a nursing home under Title XVIII of the Social Security Act ("Medicare"), and that they understand that such eligibility will continue only for a limited number of days.

While the Patient remains eligible to receive Medicare benefits (skilled nursing services) in the Nursing Home, the Nursing Home agrees to accept from the Social Security Administration the reimbursement allowed under Title XVIII and any valid regulations promulgated thereunder, as full payment for all covered services rendered under this contract, except for any applicable co-insurance and other charges legally billable to the Patient, which the Patient and Responsible Party agree to pay. Starting on such date as Medicare eligibility of the Patient terminates for any reason, as finally determined by the Social Security Administration or any duly appointed utilization review committee, the Patient and Responsible Party agree to pay the charges for services then established by the Nursing Home as the rates applicable for its services to patients who are solely responsible for payment, even if said charges will not be paid by any other reimbursement source. Any failure to pay said charges shall be a "nonpayment for the patient's stay" as that term is used in Section 21773 of the Public Health Code, and shall be a ground for involuntary discharge and transfer of the Patient from the Nursing Home, even if the Patient is then eligible to receive Medicaid benefits, unless the Nursing Home expressly agrees in writing at that time to accept payment under Medicaid as full payment.

Medicaid. If this reimbursement source is applicable, the Patient and Responsible Party warrant and represent that at the time of admission the Patient is eligible to receive nursing home service benefits under the Michigan Plan For Medical Assistance ("Medicaid").

While the Patient remains eligible for Medicaid benefits (nursing home services) in the Nursing Home, the Nursing Home agrees to accept from the State of Michigan the reimbursement allowed for nursing home services under Medicaid, as full payment for all covered services rendered under this contract, except for any applicable co-insurance and other charges legally billable to the Patient, which the Patient and Responsible Party agree to pay. For any period of admission during which the Patient is not in fact eligible for and receiving such benefits, as finally determined by the Department of Social Services, both the Patient and the Responsible Party agree to pay the charges for services then established by the Nursing Home as the rates applicable for its services to patients who are solely responsible for payment, even if said charges will not be paid by any other reimbursement source. Any failure to pay said charges shall be a "nonpayment for the patient's stay" as that term is used in Section 21773 of the Public Health Code, and shall be a ground for involuntary discharge and transfer of the Patient from the Nursing Home, unless the Nursing Home expressly agrees in writing at that time to accept payment under Medicaid as full payment. Any deposit received by the Nursing Home upon admission of the Patient may be held and applied against any payments due from the Patient and Responsible Party.

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ADMISSION AGREEMENT

Admission Agreement from Tennessee

RECEIVED

JUN 7 1984

COMMISSION ON AGING

THE PATIENT OR RESPONSIBLE PARTY AGREES TO:

FINANCIAL AGREEMENT

The patient or responsible party agrees to pay monthly, and the nursing center will accept this arrangement in full consideration for care and services rendered as follows:

accommodation type of 2-bed ICF for a basic fee of $ 40.00 per day

Agrees to pay all fees and charges not covered by insurance or public aid funds for any reason, when they are billed and thereafter

event insurance and/or public aid funds are not available.

(a) The basic rate includes room, board, and nursing/personal care.

(b) Extra charges include personal laundry, special supplies, house medications, prescription drugs, laboratory and therapy fees, personal nursing care, equipment rental, physician and private duty nursing fees, ambulance transportation, and personal hairdressing fees.

daily rate is changed for the day of admission and there is no day charge for the day of discharge if it is by 11:00 a.m.

facility rate will be charged on the day of death, if applicable.

A payment equal to 30 days routine care and services will be required upon admission.

Daily rate changers may be made at any time upon written notification.

refund of any account balance will be made within 30 days following discharge or payment in full by all public aid funds.

Deposit for spending money

Other (itemize)

$ _____

$ _____

$ _____

Sub total $ _____

Total Cost $ _____

The financial agreement with the patient, public assistance department or responsible party, if patient receives public aid is as follows:

The services for any bill rendered by the physician will be charged to the patient.

The services of the physician will be billed by him directly to the patient or responsible party.

Some of medications as ordered by the physician from the pharmacist will be charged to the patient.

Special medications as ordered by the physician will be billed by the pharmacist directly to the patient or responsible party.

DURATION OF AGREEMENT

Either party may terminate this agreement on 30 days written notice. Otherwise, it will remain in effect until discharge of the patient.

EXCEPTIONS

The parties agree to the following exceptions or additions to this agreement:

The undersigned responsible party understands and agrees that the patient cannot be eligible for a medicaid bed at our facility within (1) one year following admission.

RECORD OF AMENDMENTS TO AGREEMENT

ENTIRE AGREEMENT

The entire agreement between the parties, and it may not be amended except by written

1/84 X

DATE (SIGNATURE OF PATIENT OR RESPONSIBLE PARTY)

DATE (RELATIONSHIP TO PATIENT)

the operator of the patient

the foregoing instrument as the responsible party, for the purposes therein set forth.

WITNESS SIGNATURE Dated this ____ day of _____, 19__ NOTARY PUBLIC

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(Name of patient)

Admission Agreement from New Jersey

1. To furnish room, board, laundered linen and bedding, nursing care, and such personal services as may be required for the health, safety, and well-being of the patient.

2. To obtain the services of the physician of the patient's choice whenever necessary or to secure the services of another licensed physician if one has not been designated or is not available, as well as such medications as the physician may order.

3. If ordered by the physician, to arrange for the transfer of the patient to a hospital of the patient's choice, and to immediately notify the responsible party of such transfer.

AGREEMENT OF PATIENT OR RESPONSIBLE PARTY

1. To provide personal items, clothing, and such personal effects as needed or required by the patient.
2. To be responsible for transportation and hospital charges if hospitalization becomes necessary.
3. To notify the Nursing Home one week in advance of the patient's contemplated discharge not due to any emergency.
4. To provide for the discharge of the patient, within a reasonable time, if the Nursing Home finds that the patient is or becomes "noisy", uncontrollable, markedly uncooperative, or disturbing to the comfort of the other patients.

FINANCIAL AGREEMENT

The patient or responsible party agrees to pay weekly and the Nursing Home will accept this arrangement in full consideration for care and services rendered as follows:

1. Room, board, laundered linen and bedding, nursing care, and personal services. $.....

( ) XXXXXXXXXXXXXXXXXXXX $.....

( ) 3. Incontinence $.....

( ) 4. Feeders $.....

4a) The Nursing Home will accept Medicaid as pmt only after the patient has paid privately for one year. Total $.....

( ) 5. The services for any bill rendered by the physician will be charged to the patient.

( ) 6. The services of the physician will be billed directly to the patient or responsible party.

( ) 7. Medications as ordered by the physician will be charged to the patient.

( ) 8. Medications as ordered by the physician will be billed by the pharmacist directly to the patient or responsible party.

9. There will be a minimum charge of one week.

10. The day of admission, or the day of discharge will be charged for a full day regardless of the hour of admission or discharge.

_____ _____

Date Signature

Relationship

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Admission Agreement from New Jersey

(e) Hereby gives, grants, conveys, transfers and assigns to the Home, and its successors, IN TRUST, NEVERTHELESS, for the uses and purposes hereinafter expressed, the real and personal property hereunder listed, all of such property to be under the management and control of the Home as Trustee for the Resident, but such trusteeship to be automatically terminated at any time that the Resident either ceases to be a Resident or becomes a recipient of any form of public assistance from the Federal Government and/or the State of New Jersey or any political subdivision thereof;

(f) Agrees that the Home may solicit or require contributions or payments to be made by relatives of the Resident, or other persons or agencies interested in the Resident, on the Resident's behalf, provided, however, that all such contributions shall become a part of and credited to the trusteeship account or accounts above referred to, and shall be used by the Home as payments on account of, rather than in addition to, the obligations referred to in subsection (a) above;

(g) If no trusteeship account or accounts are established, or if, having been established, they should become exhausted through periodic reductions of the obligation referred to in subsection (a) above, and through other withdrawals by the Resident, and the Resident at any time becomes financially unable to make the payments required under subsection (a) or to procure the making of such payments by others on his behalf, then and in such event the Resident agrees to apply for any form of public assistance to which he may at such time be entitled under the laws of the Federal Government and/or the State of New Jersey, and agrees, if granted such public assistance, to pay therefrom to the Home the

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39-718 O - 84 - 6

Admission Agreement from New York State
(The Glengariff Corporation)

ADMISSION AGREEMENT
(Private Patient - Nursing Home)

[redacted]

nt's Name: [redacted]

nt's Address: [redacted]

of Sponsor: [redacted]

ess of Sponsor: [redacted]

(One of Sponsor: (Home) [redacted] (Business) [redacted]

The Nursing Home section of The Glengariff Corporation (hereinafter called Facility), nt and Sponsor hereby agree to the following terms and arrangements concerning room, board, ing care, physician responsibility and other items..

1. The Glengariff Corporation hereby admits the Patient to the Facility. In consideration, Patient and Sponsor agree to pay The Glengariff Corporation its basic charge for the basic lity services furnished (itemized in the following paragraph 2) at the current daily basic ra 95.60 for a PRIVATE room, or at such increased basic rate that shall comply with graph 6 below. Such charges shall be paid in advance, on a monthly basis. Bills will be ered on the 25th of the month and shall be payable on or before the 5th of the following mont Glengariff Corporation shall be entitled to the then current basic charge for a full day, if Patient should be discharged after 11 A.M. *Patient or Sponsor has deposited $. with Glengariff Corporation (by check subject to collection) as security to be held and disposed et forth in paragraph 2) of this agreement. Patient and Sponsor acknowledge and agree that Glengariff Corporation is not obligated to accept Medicaid payments in lieu of the private ents from the Patient and Sponsor required hereunder unless and until (a) the Patient shall been a patient in the Facility for a period of at least 30 months and (b) the Patient and sor shall have paid in full all sums due The Glengariff Corporation hereunder from the Patie Sponsor for all periods prior to the first actual receipt of such Medicaid payments and shal performed in full all of the obligations under this agreement on their part to be performed ing such period. The Glengariff Corporation will credit against the sums due The Glengariff oration hereunder from the Patient and Sponsor any reimbursements actually received from icare for Facility services and items furnished by The Glengariff Corporation to the Patient. after any commencement of Medicaid payments to The Glengariff Corporation in respect of the ient that The Glengariff Corporation is obligated hereunder to accept in lieu of private ents from the Patient and Sponsor, such Medicaid payments should, at any time or from time t n, stop for any reason whatever, the Patient and Sponsor agree to pay The Glengariff Corporat charges hereunder from the date of such stoppage until such time as Medicaid payments in pect of the Patient are resumed.

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Admission Agreement from Pennsylvania

DATE: 8/29/84

RE: Mrs. SOC. SEC.#

Dear Mrs

Hopkins House, Inc. agrees to accept the above named patient under the Commonwealth of Pennsylvania Medicaid Program after 30 months as a private pay patient from the date of admission and the private funds of the patient have been exhausted.

The patient must be certified by the Commonwealth of Pennsylvania according to the regulations of the Commonwealth of Pennsylvania Medicaid Program at that time.

ADMINISTRATOR

I HAVE READ THIS LETTER AND UNDERSTAND THE CONTENTS.

RESPONSIBLE PARTY DATE

See Appendixes 1 thru 5

SUPPLEMENTAL STATEMENT OF TOBY S. EDELMAN, STAFF ATTORNEY, NATIONAL SENIOR CITIZENS LAW CENTER, WASHINGTON, DC

I. Introduction

Thank you for the opportunity to supplement my oral testimony before the committee on October 1, 1984 with more technical written testimony.

The hearing provided vivid evidence of the fact that nursing home discrimination against Medicaid recipients is a pervasive problem. There can be no question that nursing homes discriminate against Medicaid recipients and that recipients and their families suffer significantly as a result.

The points I wish to make in this written testimony are as follows:

(1) Facilities discriminate in a variety of ways. Whether facilities impose private-pay requirements on applicants for admission or whether they manipulate their provider agreements with State Medicaid agencies, their purposes are controlling the number of Medicaid recipients and increasing the number of more profitable private-pay residents.

(2) Discrimination occurs because of high occupancy rates in facilities, limited numbers of available beds, and the fact that Medicaid rates are lower than private-pay rates.

(3) Documentation of widespread discrimination is increasing at both the Federal and State levels. It is essentially an acknowledged fact that nursing homes discriminate.

(4) States have begun addressing discrimination through State remedies at the legislative and administrative levels. States are beginning to act in this area because of the absence of a clear and cohesive Federal policy outlawing discrimination.

(5) There is a need for a stronger Federal commitment to prohibiting discrimination against Medicaid recipients. The Federal Government needs to enforce its current interpretations that prohibit discrimination. In addition, Federal law needs to state clearly what Medicaid participation means. An affirmative statement must describe what responsibilities Medicaid providers undertake when they voluntarily choose to participate in the Medicaid program. The Federal and State governments must then be authorized both to monitor facilities' compliance with the requirements that are enacted and to enforce compliance with those requirements.

II. Nursing Home Discriminate Against Medicaid Recipients in a Variety of Ways That Enable Them To Restrict the Number of Medicaid Residents and To Increase the Number of Private-Pay Residents

The Medicaid program is structured so that with a few exceptions,[1] providers can choose whether or not to participate. Nursing homes may participate in Medicaid for a short time, then withdraw from participation entirely.[2]

In addition, facilities that participate do so on their own terms. Generally, the fact of participation means only that facilities will be reimbursed, on a per capita per diem basis, for the care and services they provide to however many Medicaid recipients they choose to serve. Nothing in the Federal Medicaid law obligates nursing homes to provide care for specific recipients. Facilities determine their own level of participation, use Medicaid for their own purposes, and make unilateral (and usu-

[1] Public and nonprofit facilities that received funds and loans for construction and/or modernization under the Hill-Burton program, 42 U.S.C. § 291, are required to participate in the Medicaid program. 42 C.F.R. § 124.603 (c)(1)(ii)(1983).

[2] *See Stitt* v. *Manor Care, Inc.*, No. C78-630 (N.D. Ohio, Oct. 24, 1978), [1979-1 Medicare and Medicaid Guide (CCH) ¶29,409.

ally unchallenged) decisions whether to admit or refuse Medicaid recipients seeking admission.

Discrimination against Medicaid recipients in admission takes many forms, all of which are designed to increase facilities' private-pay census. Some facility practices focus on their relationship with residents. Some facilities claim to have no beds when an inquiry is made for a Medicaid recipient and place people's names on fictitious waiting lists. Other facilities ask for "voluntry" contributions to a building fund before they will admit a recipient. Still others place clauses in their admission countracts requiring that residents agree to pay for care out of private funds for a specified period of time, generally ranging from several months to several years, before Medicaid payments will be "accepted" on their behalf.

Facilities engage in other discriminatory practices, by manipulating their contracts with State Medicaid agencies, which limit the number of beds that are even theoretically available for Medicaid recipients. They may sign provider agreements with the State agency that limit the number of Medicaid certified beds thay have (limited bed provider agreements) so that a 100-bed facility, for example, may have only 10 Medicaid certified beds, or they may certify for Medicaid participation only one floor or wing (distinct part certification), rather than the entire facility. The effects of these practices are that residents are admitted as private-pay (even if they are eligible for Medicaid) and that facilities use Medicaid only for their own private-pay residents who exhaust their personal financial resources and convert to Medicaid. Rarely do Medicaid recipients get admitted from the communty when these practices are in place.

Practices such as these are widespread and pervasive throughout the nursing home industry.

III. Nursing Homes Discriminate Against Medicaid Recipients Because Private-Pay Residents Are More Profitable Than Medicaid Residents

The nursing home industry claims that preference for private-pay residents occurs only because Medicaid rates are too low to cover facilities' costs. This is simply not true.

We cannot accept at full value facilities' claims that Medicaid reimbursement is too low. Medicaid reimbursement is admittedly lower than private-pay rates,[3] but it is not necessarily inadequate. It is recognized that many facilities are able to provide excellent care with Medicaid reimbursement.

Moreover, if low reimbursement were the cause of discrimination, we would not expect to see discrimination in States with high reimbursement rates. Yet, New York, with reimbursement rates among the highest in the country, has a documented problem of discrimination.

No matter how high the Medicaid rate, facilities will discriminate against Medicaid recipients if the private-pay rate is higher. Since few States regulate private-pay rates in any way, facilities can virtually always raise their private-pay rates whenever they choose. As a result, increasing Medicaid rates will not necessarily improve access for Medicaid recipients to any considerable extent. Florida learned this lesson recently. The State legislature increased the Medicaid reimbursement rate, with industry assurances that access problems would decrease as a result. The Florida Long-Term Care Ombudsman Council, however, reports that discrimination has not abated and that "access to care is still primarily available only for those who can pay the private rates." [4]

So long as there is some difference between Medicaid and private-pay rates and so long as occupancy rates are high and there is a shortage of beds, there will be discrimination against Medicaid recipients. This problem can only intensify. As Medicare's prospective reimbursement system (DRG's) for acute case hospitals is implemented and more Medicare and private-pay patients begin looking for long-term care beds, access for Medicaid recipients will decrease. In addition, the increasing dominance in the long-term care field of multi-State proprietary chains that openly seek to increase their private-pay census will adversely affect Medicaid recipients' ability to find needed beds.

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[3] In part, this occurs because Federal Medicaid law prohibits the Medicaid program from paying more than the private-pay rate. 42 C.F.R. § 447.325 (1983)

[4] State of Florida, annual report of the Long-Term Care Ombudsman Council, at 15 (1983).

IV. Documentation of Widespread Discrimination Is Increasing at Both the Federal and State Levels

While the existence of pervasive discrimination is becoming a generally recognized fact, documentation of the problem is also steadily increasing.

The most recent General Accounting Office report on nursing homes, "Medicaid and Nursing Home Care: Cost Increases and the Need for Services Are Creating Problems for the States and the Elderly,"[5] devoted one of its five chapters to the problem of discrimination. A 1980 Inspector General's report on hospital backup found that people remaining unnecessarily hospitalized and awaiting nursing home placement are generally poorer, older and sicker than patients who easily find long-term care beds.[6]

States report similar findings of discrimination. In a July 1983 report, the New Jersey Nursing Home Task Force stated, "The use of private pay contracts within the nursing home industry is widespread and has become standard practice."[7] It reported that only 45 of the State's 221 nursing homes participating in Medicaid fail to require such contracts and continued:

"Based on a survey conducted by the State's nursing home industry, it is *estimated* that roughly 16 percent of the private-pay patients in nursing homes participating in Medicaid are eligible for Medicaid coverage. In other words, about 1,800 of the 11,400 private pay patients could have their care paid for by Medicaid if it were not for the terms of their contracts. [Emphasis in original.][8]

The Florida Health Care Association estimates that one-third of the private-pay residents are eligible for Medicaid but pay privately.[9] The Maryland Nursing Home Association in litigation, asserted, "For many years, it has been a common practice in the long-term care industry for most, if not all, Medicaid facilities to include duration of stay agreements in their admission contracts with patients who are admitted to the facilities as private pay patients."[10] (The other common method cited by plaintiffs as enabling facilities to achieve "the proper patient mix"[11] is distinct part certification.)

Ohio has called discrimination against poor elderly and disabled people "rampant."[12] (Section F of the final report of the Ohio Nursing Home Commission, entitled "The Problem of Discrimination," is attached as appendix A.) California identified the serious problem of discrimination in 1980[13] and again in 1983.[14] (The section of the 1983 report, "The Bureaucracy of Care: Continuing Policy Issues for Nursing Home Services and Regulation," that describes discrimination is attached as appendix B.) The Florida Long-Term Care Ombudsman Council called discrimination a legislative priority for 1984.[15] (The section of the 1983 annual report of the Long-Term Care Ombudsmnan Council describing the problem is attached as appendix C.) In fiscal year 1982, the State nursing home ombudsmen identified discrimination against Medicaid recipients as the fourth most significant problem, cited by 20 States and the District of Columbia.[16]

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[5] GAO/IPE-84-1 (Oct. 21, 1983).

[6] HHS, Office of the Inspector General, Restricted Patient Admittance to Nursing Homes: An Assessment of Hospital Backup, Secretarial Report, at 2 (August 1980).

[7] Report of the Nursing Home Task Force of the State of New Jersey 74 (July 21, 1983).

[8] Id., at 75.

[9] State of Florida Long-Term Care Ombudsman Council, "Comments on CS/SB 636," at 3.

[10] *Health Facilities Association of Maryland* v. *Schweiker*, Civil Action File No. R82-2917 (D.Md., filed Oct. 4, 1982), Memorandum in Support of Plaintiff's Motion for Summary Judgment and in Opposition to the Motion for Summary Judgment by Defendants Buck and Green, at 8 (filed Dec. 16, 1982).

[11] Id., at 9.

[12] The Ohio Nursing Home Commission, "A Program in Crisis: Blueprint for Action" (final report) (November 1979), at 194.

[13] California State Legislature, Assembly Office of Research, "Facilitating Access to Skilled Nursing Facilities for Indigent Patients" (February 1980).

[14] Commission on California State Government Organization and Economy, "The Bureaucracy of Care: Continuing Policy Issues for Nursing Home Services and Regulations" (August 1983).

[15] See note 4, supra, at 11.

[16] HHS, Administration on Aging, "National Summary of State Ombudsman Reports for U.S. FY 1982," at 30, 35 (AoA-IM-84-11) (Dec. 16, 1983).

V. States Have Begun Outlawing Discrimination Through Legislative and Administrative Methods

In the absence of clear and direct Federal prohibitions against discrimination, some States have dealt with the problem by enacting State legislation or by promulgating State regulations.

Most States that have addressed the issue of discrimination have placed obligations on facilities that voluntarily choose to participate in the Medicare program.

The Massachusetts public assistance manual, in a provision entitled "Provider Discrimination Against Medicaid Recipients—Long-term Care Provider Responsibilities," requires that Medicaid-participating facilities admit eligible Medicaid recipients seeking admission if beds are available at the required level of care.[17] Facilities may not maintain separate waiting lists for private-pay and Medicaid recipients, but must admit all applicants on a first-come first-served basis. The antidiscrimination provision was upheld by a State court,[18] and has been enforced by the State attorney general in several lawsuits.[19]

Minnesota law requires nursing homes participating in Medicaid to agree, as a State condition of participation, not to charge their private-pay residents a higher rate than the Medicaid rate.[20] If Nursing homes have no financial incentive to prefer private-pay residents over Medicaid residents, they can be expected not to discriminate against Medicaid recipients in either admission or conversion situations. The rate equalization law has been upheld.[21]

Ohio law places obligations on participating facilities not to discrimnate against Medicaid recipients through provider agreement requirements.[22] Provider agreements must include clauses prohibiting facilities from refusing to admit Medicaid recipients. Residents are given a private cause of action to enforce the nondiscrimination provisions.[23]

A Connecticut law called "An Act Prohibiting Discrimination Against Indigent Persons Who Apply for Admission To Nursing Homes," requires admission on first-come first-served basis.[24] Facilities must conspicuously post notices of their obligations under the law and of residents' remedies (including the name, address and telephone numbers of regional ombudsmen).[25] Facilities must maintain daily logs of requests for admission, vacancies, and admissions.[26] The regional ombudsman may investigate complaints[27] and the State Department of Income Maintenance is authorized to decrease the daily reimbursement rate of facilities that violate the law. A 1984 amendment requires facilities to give applicants dated receipts and to maintain and make available waiting lists.[28]

New Jersey, in contrast to the States discussed above, imposes obligations on nursing homes to provide nursing home care to Medicaid recipients. State health department regulations, entitled "Beds for Indigents," authorize the Department to require long-term care facilties to provide care for indigent people (defined as Medicaid recipients or Medicaid-eligible individuals) in order to receive State licenses.[29] Since facilities may not do business at all without a State license, the regulations effectively require nursing homes in the State to provide care for some Medicaid recipients in order to conduct their business. The New Jersey Supreme Court, affirming a decision by the Appellate Division of the Supreior Court, upheld the regulations and held that nursing homes are 'quasi-public" facilities.[30]

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[17] Massachusetts Public Assistance Manual, Ch. VII, A, part 3, Subsection I.B.I.
[18] *Massachusetts Federation of Nursing Home and Related Facilities, Inc.* v. *Sharp*, No. 18915 (Massachusetts Superior Court, Mar. 16, 1977).
[19] *Bellotti* v. *Kimwell Nursing Home*, 124 745 (Massachusetts Superior Court, Norfolk County filed and settled June 23, 1978), *Commonwealth* v. *Twin Pines Corp.* No. 78-2768 (Massachusetts Superior Court, Middlesex County, filed May 24, 1978 and settled May 28, 1979).
[20] Minn. Stat. Ann. § 256B.48
[21] *Minnesota Association of Health Care Facilities* v. *Perpich, Medicaid Guide* (CCH) ¶34,105 (8th Cir., August 28, 1984).
[22] Ohio Rev. Code Ann. § 5111.31.
[23] Id., at § 5111.32
[24] Conn. Gen. Stat. § 19-614a.
[25] Id., at § 19-614a(b)(2).
[26] Id., at § 19-614a(b)(4).
[27] Id., at § 19-614a(c).
[28] Id., at § 19a-533.
[29] N.J. Adm. Code 8:30-14.3.
[30] *New Jersey Association of Health Care Facilities* v. *Finley*, 415 A.2d 1147 (N.J. 1980), cert. den., 101 S.Ct. 342 (1982).

Recent State efforts to outlaw discrimination have focused on particular forms of discrimination, particularly private-pay duration of stay contracts. Virginia,[31] Maryland,[32] Washington,[33] and New York [34] have all specifically outlawed private-pay contracts (copies of thier rulings are attached as appendices D through G, respectively) and similar express prohibitions are under consideration in Michigan and New Jersey. The States have typically reached this decision through interpretation of the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977. 42 U.S.C. § 1396h(d) makes it a felony under Federal law for a long-term care facility to charge a Medicaid recipient any amount in addition to the sum paid by the State or to charge, solicit, accept or receive "any gift, money, donation or other consideration" as a condition of admitting a medicaid recipient. Since facilities receive "other consideration" (the higher private-pay rate) by requiring prospective residents who are Medicaid-eligible to pay private rates for specified periods of time, States conclude that the practice of requiring private-pay contracts is unlawful. Recent analysis of private-pay contracts also finds that such contract requirements violate State consumer protection law and common law contract principles because such clauses illegally seek to prevent people from exercising their right to apply for Medicaid.[35]

VI. The Federal Government Needs To Make a Stronger and More Coherent Commitment to Outlawing Discrimination Against Medicaid Recipients

A. THE FEDERAL GOVERNMENT NEEDS TO ENFORCE ITS INTERPRETATIONS OF CURRENT LAW THAT PROHIBIT DISCRIMINATION

Many of the discriminatory practices described above are already viewed by the Health Care Financing Administration as illegal. Yet HCFA does virtually nothing to ensure that States follow its interpretation of the law.

A key example is limited bed provider agreements. As noted above, facilities use limited bed agreements as a way of restricting the number of Medicaid certified beds in a facility. HCFA views the practice as inconsistent with Federal Medicaid regulations, but enforces its interpretation only when a State requests a waiver of Medicaid regulations in order to use limited bed agreements. HCFA has denied both Mississippi's and South Carolina's waiver petitions to have limited bed agreements. (See May 29, 1981 letter from Carolyne Davis, Director of HCFA, to B. F. Simmons, director, Mississippi Medicaid Commission, and Memorandum to Regional Administrator, Region IV, from Director of HCFA's Bureau of Eligibility, Reimbursement and Coverage, August 22, 1983, appendices H and I respectively.) However, so long as a State does not seek permission to use limited bed agreements—and simply enters into such contracts—HCFA does nothing. As a result, many States, including Virginia and Kentucky, use such contracts and HCFA raises no question.

On the issue of private-pay duration of stay contracts, HCFA again views the practice as illegal, but is unwilling to take any action to enforce its view. In a June 14, 1983 memorandum to the Regional Administrator in Region II (appendix J), the Director of HCFA's Bureau of Eligibility, Reimbursement and Coverage states "in the case of a private pay patient who becomes Medicaid eligible, and Medicaid assumes the cost of care in the facility, a contractural provision requiring the continued payment of private pay rates seems contrary to § 1909(d)(2)(B)." He finds "contrary to the statute" a private-pay contract with a resident who is eligible for Medicaid at the time of admission. Despite the opinion that the facility practice of requiring private-pay contracts is illegal, the Director claims that his advice can only be provided on an "informal basis."

"The Office of the General Counsel has advised us that section 1909(d) is a criminal statute and that no one within the Department can give a definitive interpreta-

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[31] Medicaid Memo NH-57, Apr. 21, 1980.

[32] Attorney General's July 7, 1982 Advice of Counsel letter, distributed to Medicaid nursing homes on July 9, 1982 by the Department of Health and Mental Hygiene as an Advisory Notice, upheld in *Summit Nursing Home* v. *Medical Care Programs, Department of Health and Mental Hygiene*, Hearing Office Docket Nos. 82-MAP-264, et al., May 8, 1984, Medicare and Medicaid Guide (CCH) ¶ 33,977.

[33] Department of Social and Health Services, Dear Nursing Home Administrator Letter (Aug. 19, 1983).

[34] New York State Health Department, "Questions and Answers Pertaining to Written Admission Agreements Between Residential Health Care Facilities and Patients/Residents," Series 84-54 (June 13, 1984).

[35] *Summit Nursing Home* v. *Medical Care Programs, Department of Mental Health and Hygiene*, supra note 32, Medicare and Medicaid Guide (CCH) ¶ 33,977, at 9352.

tion regarding the scope and applicability of a criminal statute since those matters are within the province of the Department of Justice, individual U.S. Attorneys, grand juries, and ultimately the courts. Where information is available suggesting a potential violation of section 1909(d), such cases should be referred to the Office of the Inspector General for investigation and appropriate action (e.g., referral to the appropriate U.S. Attorney's office."

Memorandum, at 1. HCFA issued a similar policy information memorandum, with a similar suggestion of referral to the Inspector General, in an August 22, 1983 Policy Information Memorandum (appendix I).

It seems quite plain that at the very least, on both these issues—limited bed agreements and private-pay contracts—HCFA should be advising the States and Regional Offices of its interpretations and ensuring that these interpretations are consistently followed throughout the country.

B. NEW FEDERAL LEGISLATION IS NEEDED TO CLARIFY NURSING HOMES' OBLIGATIONS AS MEDICAID PROVIDERS

While clear and consistent enforcement of the Federal interpretations described above would help alleviate discrimination against Medicaid recipients to some extent, there is a need for additional legislation to State in affirmative terms what nursing homes must do as participants in the Medicaid program. The law is developing now in a defensive posture, chiefly by drawing inferences from Federal criminal law. We need to state clearly and affirmatively what providers must do if they wish to receive Medicaid reimbursement.

Congress may want to look closely at the various State approaches described above to decide which approaches, singly or in combination, would be appropriate for Federal legislation. The General Accounting Office could be asked to analyze the State approaches to determine such comparative factors as effectiveness, problems, and appropriate modifications.

In addition to spelling out the obligations of facilities to provide services in a nondiscriminatory manner, Federal legislation must also create mechanisms to monitor facilities' compliance with whatever requirements are enacted. If compliance cannot be validated, it will not be achieved. Finally, Congress needs to enact a variety of mechanisms, both public and private, for enforcing the statutory obligations. Public enforcement is a critical element of legislation because so many residents and their families are fearful of challenging facility practices and demands.

I commend the committee for exploring the issue of discrimination against Medicaid recipients. I am hopeful that with your work, we will begin ensuring that Medicaid nursing homes provide care to the poor, elderly and disabled people who need their services, without regard to their source of payment. I look forward to working with you as you continue your work in this area.

From The Ohio Nursing Home Commission, A Program in Crisis: Blueprint for Action (Final Report) (November 1979).

SECTION F. THE PROBLEM OF DISCRIMINATION

A final problem addressed by the Commission's recommended reimbursement system is that of discrimination against those elderly and disabled nursing home patients who require public assistance in paying for their long-term health care.

1. Shortage of Nursing Home Beds for Medicaid Recipients

In Akron, an elderly widow testified before the Commission about the difficulties she had encountered in finding a nursing home which would accept her sister, paralyzed by a stroke. The widow canvassed nursing homes in sixteen surrounding counties for six months before one finally agreed to care for her sister. And the problem was not race or religion or even the need for skilled care; it was money.

Initially, the sister's care in both the hospital and a nursing home was covered by Medicare. But the one hundred days allowed by Medicare was exhausted, and it was apparent that the sister would continue to require extensive personal and nursing care for the remainder of her life. Round-the-clock nursing care at home was financially impossible for the two women, and care in a nursing home seemed the most reasonable alternative for the sister's health care needs. However, the combined retirement income of the two women, who lived together, was inadequate to cover both the cost of nursing home care at $700 to $950 per month and the living expenses of the widow. The sister was eligible for and needed the assistance of the state's Medicaid program to cover the high cost of the health care she required.

Unfortunately, the nursing home in which she was a Medicare patient refused to let her stay on as a Medicaid recipient. The widow found that this was true for most of the homes she contacted. Those who could provide the care needed had long waiting lists for Medicaid recipients, much longer than the waiting period for private-paying patients. Other homes agreed to accept Medicaid only after the sister had been a private-paying patient for one to two years. The situation became more tragic and desperate for the widow with each passing month, until finally after a half-year of waiting, one nursing home relented and accepted the sister. Sadly, this is not an isolated situation.

a. The Scope of the Problem of Discrimination Against Medicaid Patients

One of the most serious problems with Ohio's nursing home program is the ramnant discrimination against many elderly and disabled individuals. According to testimony received by the Nursing Home Commission from relatives of nursing home patients, county welfare workers, and hospital social workers across the state, it is extremely difficult to find nursing homes which provide high quality of care which will accept patients whose care is paid for by Medicaid.

The Ohio Nursing Home Commission has received testimony at each of seven regional public hearings across Ohio and in hearings in Columbus about discriminated against Medicaid recipients in or seeking admission to nursing homes. The Nursing Home Ombudsman Program at the Ohio Commission on Aging has received similar complaints. Basically, the Commission heard of the following kinds of problems.

Some homes flatly refuse Medicaid recipients; others will accept Medicaid payment only if the patient has been in the nursing home for a lengthy period , often two years, as a private-paying patient. Otherwise, they discharge the patient once they switch from private-paying to Medicaid. Still other nursing homes have told hospital discharge planners that they will accept a Medicaid recipient from the hospital only if the hospital also places a private-paying patient in the home at the same time.

Nursing home administrators and owners have told us that they often set quotas on the number of Medicaid recipients they will accept in their nursing homes. County welfare workers and hospital discharge planners have thus found that there are two sets of waiting lists for vacancies in homes. One county welfare worker called a home in Franklin County attempting to place a Medicaid recipient there. The worker was told that there were no vacancies and that there was a three to six-month waiting period for placement of a Medicaid recipient in the home. Later in the same day, the worker called and inquired about placing a private-paying patient and was told there was a bed immediately available.

In addition to not readily accepting Medicaid recipients, some facilities have "dumped" Medicaid patients from the facility to make room for private-paying residents. One of the most common ways of "dumping" a patient is for a home to discharge the Medicaid patient to the hospital for treatment, although such a transfer is not medically necessary. We have received extensive well-documented evidence of this practice from relatives and friends of nursing home patients and from hospital social workers. Several witnesses have shown that hospitals refused their relatives admittance because the relative had no need for hospital care. In one such instance, the elderly Medicaid patient was returned to the nursing home within forty-five minutes of her transfer to the hospital only to find that her room had been completely stripped and a new private-paying patient installed. Other nursing homes simply notify patients that when their private funds are exhausted they must leave the facility. Recently such an incident was brought to our attention by a federal judge. He called on behalf of the widow of his former law partner. The widow had lived for years in a facility as a private-paying patient, exhausted her funds, and was being discharged against her will when she became a Medicaid patient. The judge was sure that this was unfair and illegal, but in fact, there are no current Ohio laws prohibiting such action.

Of greatest concern is the fact that Medicaid recipients often have only one option of entering homes which provide poor care and conditions. Both the Commission and the Ombudsman have received many complaints from relatives, hospital social workers, county personnel, etc., about the difficulty of placing Medicaid patients in homes offering high quality care. Sadly, the Commission's study of a sample of homes providing either very good or very poor care confirmed this testimony. The Commission found that homes providing poor care have much higher proportions of Medicaid patients than do homes providing excellent care as the table on the following page shows:

Table 18 Distribution of Medicaid Patients in a Sample of Homes*

Percent of all patients in the home who are Medicaid Recipients	In High Quality Nursing Homes	In Low Quality Nursing Homes
0 - 19%	8 homes (30%)	0 homes (0%)
20 - 39%	7 homes (26%)	2 homes (7%)
40 - 59%	5 homes (18%)	2 homes (7%)
60 - 79%	6 homes (22%)	3 homes (11%)
80 -100%	1 home (4%)	21 homes (75%)

In our interim report, A Program in Crisis, the Commission concluded that Ohio is facing the development of a two-class system of long-term health care, with Medicaid recipients having ready access to care in only a few of the best homes and thus being forced to become patients in the state's worst homes.

Evidence that this is true comes from a variety of other sources as well. In a Medical Care Evaluation Study done in Ohio PSRO Region X of the state (Columbus), 10 of 14 hospital social workers surveyed (72%) reported that Medicaid recipients were much more difficult to place than private-pay patients needing the same kind of care.[14] Health systems agencies, responsible for approving the construction of nursing home beds based on community need for such beds, have identified the same problem.

Mid-Ohio Health Systems Agency recently approved the construction of 90 beds over and above the standard formula of need because the investors promised to make those beds available to Medicaid recipients, and the HSA found that there is a significant need for such beds in central Ohio.

A survey of nursing homes in Montgomery County also showed discrimination against Medicaid recipients.[15] Of 36 homes in the county, 32 are certified to participate in the Medicaid program. Of these 32 homes, four refuse to accept any new Medicaid patients, eliminating 251 beds for Medicaid patients. Two additional homes refused to reveal whether they would accept new Medicaid patients when vacancies occurred.

Several homes in Dayton accepted Medicaid patients only after the patients in question had been private-pay patients in the home for a specified period prior to becoming Medicaid patients. One home with 178 beds requires a minimum of three months of private-pay status; another with 66 beds requires that the patient be a private-pay patient for at least 18 months before the home will accept the patient as a Medicaid recipient. Another home has a separate waiting list for Medicaid patients.

At the request of the Nursing Home Commission, the ODPW Medical Assistance Supervisor for the Cleveland District also conducted a survey to determine the extent of the problem of discrimination. In combination with Metropolitan Health Planning Corporation (MHPC), the local health planning agency, the supervisor found evidence of wide-spread discrimination.[16] A questionnaire was sent to social work directors in hospitals in five counties and to nine county

*Basically, this means that of the high quality homes in the sample, only one (4%) had an occupancy of more than 80% Medicaid, 20% private-pay. However, 75% of the low quality homes had this heavy Medicaid concentration. That is because the low quality homes cannot attract private patients, but the Medicaid patients have no alternative to these bad homes. (See Section 2 for further discussion).

welfare departments (CWD's) in the greater Cleveland area.

The results of the survey indicate that the number of Medicaid patients experiencing delays in nursing home placement from hospitals was four-and-a-half-times greater than the number of private pay patients experiencing delays. Further, Medicaid eligible recipients in hospitals experienced longer delays as Table 19 shows.

Table 19. Number of Patients Whose Request for Nursing Home Placement Was Prolonged Due to Placement Problems

	Total Number of Patients			
	Medicaid		Medicare	Private Pay
Prolonged Days	CWD's Reports	Hospital Reports	Hospital Reports	Hospital Reports
0 - 5	63	25	54	14
6 - 10	27	21	26	3
11 - 20	27	18	12	1
21 - 30	9	6	8	
31 - 40	8	5		
41 - 50	7	4		
51 - 60	5	2		
Total:	146	81	96	18

Quality of care in facilities accepting Medicaid patients was also cited as a problem. Sixteen of 21 hospitals and seven of nine county welfare departments reported that the major problem in locating beds is that facilities offering quality care have long waiting lists. In fact, half of the hospitals and two county welfare departments (CWD) reported that the only beds available to Medicaid patients were in facilities which provided poor care. In addition, seven hospitals and three CWD's reported location of beds as a major problem, i.e., the facilities which would accept Medicaid patients were not accessible to the families.

The survey also revealed that many homes refuse to take the skilled, or total care, patient. Ten hospitals and three CWD's reported this as a problem. Other problems reported included refusal of facilities to hold beds when Medicaid patients were temporarily hospitalized, facilities' discharging Medicaid patients in favor of private pay patients, and facilities' refusal to guarantee to keep private pay patients on Medicaid after their money ran out.

Thus, it is clear that the problem of discrimination against the elderly and disabled who must rely on Medicaid for assistance in securing essential health care is widespread and serious throughout Ohio.

2. Explanations for Discrimination Against Medicaid Recipients

The causes of discrimination against those elderly and disabled individuals requiring nursing home care are actually fairly straightforward; however, eliminating the problem is much more complex. Four factors must be taken into account in dealing with the problem of discrimination against Medicaid recipients. The first is the growing number of elderly persons needing nursing home care and the effect of inflation on their ability to pay for such care. The second is the fact that the nursing home industry is dominated by proprietary providers. Moreover, even the non-profits have reason to desire an excess of revenues over costs in order to expand or upgrade services. The third factor is the impact of federal limitations on the construction of new nursing home beds. A fourth is the lack of alternatives to nursing home care. Complicating all these factors is the fact that some nursing home operators participating in Ohio's program

have given no evidence that they have an interest in providing even minimally acceptable care to patients in their homes.

One major factor in the discrimination controversy is the growing number of persons who require the assistance of Medicaid in paying for essential nursing home care. As previously noted, nursing home costs have risen at an incredible rate, leading all health care cost increases over the last decade. As the following table shows, the average income of elderly persons -- one out of five whom will be nursing home patients -- has not kept pace.

Table 20. Increases in the Average Monthly Income of the Elderly and in the Average Monthly Payment for Nursing Home Care.

Year	Average Monthly Payment For Nursing Home Care[17]	Average Monthly Income For an Elderly Male[18]	Average Monthly Income For an Elderly Female[18]
1964	$186	$170	$ 79
1969	$328	$178	$116
1973	$479	$342	$177
1977	$689	$461	$257

Given this disparity between the income of the average elderly person and the monthly cost of nursing home care, it is evident that most individuals needing nursing home care, particularly if they require care over a long period of time, will have to rely on Medicaid for assistance. According to estimates in a recent U.S. Congressional Budget office study,47.5% of all patients receiving Medicaid in 1974 were admitted to the homes as private-pay. After exhausting their resources, they were forced to convert to Medicaid status. Nationwide, 77 percent of nursing home patients now receive government assistance. Only 56 percent of Ohio's nursing home patients are on Medicaid,* but it is a serious problem which affects potential as well as current nursing home patients. The question remains as to why nursing homes discriminate against these individuals.

The most obvious reason is that private pay patients are more lucrative for providers. By law, Medicaid limits its payment to reasonable costs for providing nursing home care. Some providers have expenditures ruled ineligible for reimbursement by ODPW because the expenditures are determined to be unreasonably high. Rents and purchases of goods and services by the nursing home from related vendors, excessive owner salaries, management fees, some fringe benefits, etc., may be ruled excessive and thus non-reimbursable by Medicaid. For instance, an owner who pays himself a salary of more than $65,000 per year for working a reported 40 hours weekly as administrator; yet in another facility he owns, he pays a non-related administrator only $7,500 for doing the same job. Medicaid would limit reimbursement to the owner/administrator in the first case to $19,200 per year. Thus this owner uses rates charged his private-pay patients to make up the $45,000 difference. In other instances, the Medicaid program refused to reimburse nursing homes for trips to Hawaii and Las Vegas, for luxury automobiles, and for rents owners paid themselves which were as much as 800 percent higher than their actual costs. In all these cases, the burden for these disallowed expenditures was passed on by the owner to the private-pay patient.

Of course, securing rates from private-pay patients to cover these kinds of expenditures is not the only reason some providers have discriminated against Medicaid patients. The prospective rates of the past have not always covered the cost of providing new services, such as physical therapy or of caring for

*Sixty percent of the Medicaid certified beds are filled by Medicaid patients.

the "total care" patient--one who is not classified as skilled but still requires extensive daily care. Other providers object to the operation of the agencies administering the program, in particular ODPW and its Bureau of Fiscal Review. Some homes have been waiting more than six years for settlements of costs from prior reimbursement systems. Others have complained about protracted audits, (the result of ODPW problems rather than the providers), conflicting and non-uniform directions from ODPW on rules of the program, and other kinds of administrative problems.

But the undeniable fact is that a home can charge a private-pay patient whatever the market will bear, unconstrained by any definition or external determination of the reasonableness of the charge. As reported in this chapter, the private-pay rate is higher than the Medicaid rate in 90 percent of the cases reported to the Commission by providers. In effect, therefore, the Medicaid rate forms a floor for the private-pay patient. And there is no reason to expect that rational, self-interested nursing home providers will cease preferring the greater revenues generated by a private-pay patient to the lower rate and greater administrative burdens associated with Medicaid patients.

A third factor affecting the problem of discrimination is the existence of federal law regulating the construction of new nursing home beds. Since 1972, under the "1122" program and since 1978 under Certificate of Need (CON), no new health care facilities can be constructed unless they have received approval from state and local health planning agencies. The purpose of this legislation is to contain rising health care costs by preventing capital expenditures for unnecessary duplication of medical services and facilities. As a result, no new nursing home beds can be constructed unless there is documented need for such additional beds, according to a bed-need formula developed by the health planning agencies and approved by the state. Under the formulae used in Ohio, few areas need new nursing home beds, and the quality of care provided by existing facilities is not considered in determining whether or not to approve new construction -- as long as the facilities continue to be licensed by the state. While the regulations may help contain costs, they have also reduced competition between homes.

Currently, the average occupancy rate statewide is approximately 95 percent in homes participating in the Medicaid program, according to the reports they file with ODPW. One reason for this high rate is this government regulation on market entry. The other is the lack of alternatives to nursing home care, as discussed in a later section of this report. As a result, nursing home operators have been relieved of the necessity to compete simply to fill beds. They can restrict their competition to that for the most profitable patients -- those who are private-pay and the easy-to-care-for. As discussed, the impact for the elderly and disabled Medicaid patient has been disastrous. For the taxpayer it has been costly.

In 1977, the U.S. General Accounting Office found that $29 million per year was being spent on hospital care for people who required only nursing home care.[119] However, because of their expected source of payment (Medicaid) and because many required high levels of care, they were being denied admittance to the states' nursing homes who voluntarily choose to be certified for participation in the Medicaid program.

A final complication is the presence in the nursing home industry of some unscrupulous operators. While there are many dedicated health care professionals operating Ohio nursing homes, and many other competent businessmen, unfortunately, but undeniably, there are also those in the industry whose only apparent concern is with profits. In fact, it seems clear that if the health and safety of the elderly and disabled patients must be sacrificed for the sake of profits they are willing that this should occur.

The simple fact is that the Medicaid program, and the ability of Medicaid

certified providers to discriminate against Medicaid patients perpetuates the existence of such low quality nursing homes. This discrimination, forcing Medicaid patients into the only beds available -- too often those in low quality homes -- keeps these substandard homes almost fully occupied and makes them financially viable. In a true free market, with other long-term care alternatives available, these homes could not continue to exist.

The argument is occasionally advanced that the low quality homes provide substandard care because they are full of Medicaid recipients. This line of reasoning holds that low quality of care is a result of inadequate Medicaid payments. If this argument were true, the problem of substandard care would be relatively easy to correct. Simply increasing the Medicaid reimbursement rate would be sufficient to upgrade care, if this reasoning were accurate. However, the past experience and record of the low quality homes shows the fallacies inherent in this argument.

First of all, Ohio's nursing homes received Medicaid rates which exceeded their costs during 1975 and 1976, but not all used these to upgrade the homes. During this period, homes were reimbursed by Medicaid for property usage at a "flat rate" which exceeded their actual costs by at least an average of $1.25 per patient per day.120 According to an industry representative, many homes, most in fact, converted these excess funds into upgrading care and expanding the services they offered, as well as paying for sprinklers. However, as he observed nearly one-quarter of Ohio's homes took these funds only as profits. They did not use the extra funds to improve their operation. One result of this fact is a growing disparity between the average per diem rates of the high quality and low quality homes, since current rates are based on past expenditures updated for inflation. In 1975, the average Medicaid per diem for the low quality home was $16.39. The rate for the high quality homes was $18.67, a difference of only 14 percent. However, by 1978, that difference had grown to 26 percent, with the low quality homes having an average rate of $20.02 and the high quality ones $25.28.

Second, many homes which provide seriously substandard care nevertheless make substantial profits--from the rates paid by Medicaid alone. One example of a nursing home operator making tremendous profits but at the same time providing very poor care is Dr. Peter Kern.

In May, 1979, Dr. Kern pled guilty for himself and for four of his corporations to charges of forgery and bribery. According to Dr. Kern, he submitted false documents to ODPW, reporting costs far in excess of his actual expenditures incurred caring for patients in his nursing homes. At the same time, Dr. Kern was allegedly bribing a state official and receiving hundreds of thousands of dollars a year in more Medicaid monies than he was legally entitled to, some of his homes had an abysmal record in terms of quality of care.

According to state licensure surveys performed by ODH, Kern's facilities, such as Little Forest Medical Center in Youngstown had serious repeat violations. During the last four years, Little Forest has had a variety of violations of minimum licensing standards such as shortage of nurses, unsigned medicine orders, failure to follow special diets, and filthy conditions. One other continual violation involved insufficient linen. In March, 1975, the home was cited for failing to have sufficient clean linen in the facility to meet the needs of patients. In ten surveys and complaint investigations which followed, from May, 1975 through October, 1978, the home was cited for a shortage of clean linen -- including sheets, towels, blankets, and patient gowns and pajamas. During one such survey, the ODH nurse-surveyor wrote:

> *They [the nurses] often have to use the same wash cloths and towels for more than one patient and have used rags to wash and dry them [patients].* 121

The point of this depressing story of fraudulent profits and failure of regulation is that many of the homes which provide seriously substandard care do so not because Medicaid provides insufficient funds to pay for acceptable care and adequate profits but because some operators are unscrupulous. The Commission found that many homes which provide some of the worst care in Ohio have Medicaid per diem rates which are well above the average Medicaid rate for all homes and above many of the rates of the homes providing excellent care. The Medicaid rates for 80 percent of the previously mentioned sample of low quality homes were equal to or higher than the lowest rate of the high quality homes in the sample. In fact, the second highest rate in the total sample was for one of the worst homes.

Other states have similar findings. These studies have found little or no statistical connection between the reported costs (and rates) for nursing home care and the quality of services provided.[22] The Commission also found that the majority of homes which were found to be in violation of minimum federal health and safety standards in 1977, nevertheless reaped profits from their Medicaid rates. (See Table 15, page 165 of this report for further information).

Finally, we would observe that although it is true that on the average the high quality homes have higher Medicaid per diem rates than the low quality homes and that they spend more on services associated with direct patient care, it is also true that the low quality homes have managed to allocate the Medicaid funds they receive in such a way that they spend more than the high quality homes on administrator salaries, motor vehicles, and legal and accounting fees, as the following table shows.

39-718 O - 84 7

From Commission on California State Government Organization and Economy, The Bureaucracy of Care, Continuing Policy Issues for Nursing Home-Services and Regulation (August 1983).

B. A Private-Pay Resident Converts to Medi-Cal: Cause for Eviction?

Findings

1. Evictions have negative effects and are potentially numerous.

> A seventy-four year old widow with a history of congestive heart failure, high blood pressure and arthritic problems, was unable to manage at home. Adult children had cared for their mother for many years, but due to her exhaustion and increased problems with ambulation, the patient was moved to a convalescent home for long-term placement.
>
> After a year of private pay status, the family had used up all their financial resources to pay for this care. The patient was then eligible for Medi-Cal. Upon conversion the convalescent facility indicated that they did not have any Medi-Cal beds available and that the family would need to move her to another facility.
>
> The family had chosen this particular convalescent home knowing that Medi-Cal was accepted at this facility. They invested all of their private funds at this facility thinking that their mother would not be "kicked out" after their funds had been exhausted. The convalescent home claimed that a two year guarantee of private pay status was in effect, but the family knew nothing about this requirement.

This case, submitted by discharge planners at a large hospital, is one of many described in Commission files and recent testimony. One testifier concluded:

> Medi-Cal evictions reveal the fact that nursing home residents are treated as commodities. Often these patients are paying well in excess of the cost of their care while private patients, and are tossed out as worthless because their care is now reimbursed at the Medi-Cal rate.

Whether done openly, as above, or with more subtlety, as where the converting resident suddenly is transferred to an acute hospital and her bed is not held, such transfers have many negative effects. The discharge planner who submitted the above case concluded:

> The emotional upset created by this situation is overwhelming for all parties. The elderly patient has to relocate and readjust to an already depressing situation. His family or "responsible party" has to deal with the stress and feelings

> of helplessness when all other financial resources except monthly income are gone. The acute hospital facility spends an inordinate amount of time trying to find another bed for the patient. [Where] there is an already existing shortage of Medi-Cal beds,...this has become a formidable task. ...Often a patient has to be placed miles away from his family (who are often elderly as well) and friends who had hoped to visit the patient on a regular basis.

According to some gerontologists, forced relocation of frail elders, especially if callously handled, can actually cause further debilitation and sometimes even death.

What is the actual extent of this problem? Nobody knows. Statistics cannot be derived from Medi-Cal authorization forms, because so often the resident is transferred first to acute care and only later to another nursing home. A recent survey of ten San Francisco nursing homes found only one that permits all converters to remain, and five that evict all converters (four of these do not participate in Medi-Cal at all).[8] The remaining four keep converters only after they have paid private rates for a certain period of time, varying all the way from 4 months in one case up to 4 years in another. Only two facilities had contracts spelling out their conversion policy; the others relied on oral agreement alone.

2. When facilities take on residents, they take on obligations.

Opinions differ over whether eviction of patients who convert to Medi-Cal is permissible under current law. The industry argues that Medi-Cal is a voluntary program and providers can therefore choose which and how many Medi-Cal recipients they wish to serve. Consumers argue that under state regulations residents may not be transferred except for medical, welfare, or nonpayment reasons. They say that although participation in the program may be voluntary, if a facility

does participate, it is obliged to accept Medi-Cal rates as payment in full for Medi-Cal recipients; thus, it would not be permissible for a participating facility to evict a converting resident for nonpayment. The Attorney General has been asked to resolve this question.

The Commission finds that when a facility admits any resident to its care, it accepts special obligations toward her; that when it forces her to uproot, it may inflict special harm upon her; and that justice therefore demands retention of converting residents by any facility which participates in the Medi-Cal program. But once this rule has been established, either by legal opinion or by remedial legislation (as has been done in a number of states), other difficulties may be anticipated.

3. Evictions are part of a broader Medi-Cal discrimination problem.

Medi-Cal evictions take place in a broader context of discrimination against all Medi-Cal residents. The Assembly Office of Research in 1980 reported clear evidence that many facilities in certain areas of the state discriminate against Medi-Cal recipients, especially those needing heavy care.[9] The report found that state-imposed limits on total bed supply and on Medi-Cal reimbursement for heavy care combined to produce market conditions which backed up such patients in acute care beds, working counter to the state's own goal of meeting the greatest needs at the lowest reasonable cost. This discrimination is likely to increase. For example, chain owners nationwide are "scrambling for more private-paying patients," and some will not buy a facility unless at least 50 percent of its residents are private-pay.[10]

The industry argues that a facility which wants to provide good care and make a profit has to limit its census of Medi-Cal residents and balance them out by charging private residents rates which are more than the actual cost of care. Thus, if facilities are required to keep all converting residents, they will attempt to compensate for any Medi-Cal/private-pay imbalances by lowering the quality of care and/or by other means such as:

- More private admission contracts under which residents remain private pay for a certain time before converting, and the facility agrees to keep them after that time. This is the solution favored by the California Association of Health Facilities. However, such contracts have been held illegal by Attorney General opinions in a number of states (e.g., Maryland), because they place a precondition on Medicaid admission in violation of the federal antifraud statute. The same would be true of other preconditions, such as required "contributions" or agreement by another person to make extra payments for Medi-Cal covered services.

- A sudden need for acute care around the time of conversion to Medi-Cal, followed by placement of a private-pay resident in the hospitalized resident's bed. This technique, already used in California, has been countered in other states by mandatory bed-hold policies. A few days does not appear sufficient; statutes more typically require that beds be held open for around 15 hospital days. In view of the difficulty and delay often experienced in locating another bed (Finding 1), this potential price is not inordinately high. A variant of this type of "medical" transfer involves residents who have come to need heavier care than the facility can provide. If true, the transfer is not only

legitimate but required by law. However, transfer of "heavy care" residents by a facility which is qualified to serve them probably violates federal law.[11]

• Limited-bed provider agreements, under which facilities contract with the state to make only a small percentage of their beds available to the Medi-Cal program. Then, if that quota is filled at the time a resident converted, the resident could be evicted for nonpayment on the ground that there is no mechanism by which the state could reimburse the facility for an additional bed. The legality of such agreements is uncertain. Some state Medicaid agencies (e.g., Connecticut) refuse to enter them as a matter of policy; Ohio prohibits them by state law.

• Refusal to accept Medi-Cal admissions, giving admission preference to the wealthiest private applicants, etc. A number of states have met such discrimination head-on by enacting statutes or regulations that mandate a first-come, first-served admissions policy (e.g., Connecticut, Massachusetts, Ohio). Minnesota's approach is indirect; Medicaid-participating facilities may charge private-pay residents no more than Medicaid rates for the same services. Both types of legislation have been upheld against the industry's legal challenges. The federal district court which upheld the Minnesota law in April 1983 said that it furthered "strong societal purposes" and that it:

> 1) may reduce discrimination against Medicaid recipients in gaining entry into nursing homes by eliminating the incentive to discriminate; 2) tends to alleviate the 'stigma' attached to receiving welfare benefits; 3) permits private pay residents to stretch their savings further and thereby stay off welfare; 4) promotes the fundamental notion of fairness that one should pay equal rates for equal services; and 5) eases the resentment of private pay patients directed toward Medicaid recipients.[12]

• Dropping out of the Medi-Cal program altogether. This has not been a major problem in states which have enacted strong anti-discrimination laws. It is a perennial threat which most facilities cannot follow up if they want to remain in business, since over 70 percent of potential residents are on Medi-Cal. (On whether Medi-Cal rates are really inadequate, and if so what should be done about them, see Section A above.)

If indeed many facilities drop out, New Jersey's approach could be considered. There, relatively few facilities participated in Medicaid, so the state passed regulations requiring every facility, as a condition of receiving its state license, to serve a reasonable proportion of indigents, either through Medicaid or directly. Those regulations were upheld by the state supreme court, which found that privately owned nursing homes are quasi-public entities, and should be required to share in the burden of caring for indigents.

This approach, while it appears more equitable in that all facilities bear the load equally, has proven something of an administrative morass in practice. The California Assembly Office of Research, in its 1980 study, preferred to keep it for a last resort, though recommendations did include conditioning all certificates of need on making available a certain quota of Medi-Cal beds. The Attorney General has since held that such conditions are not only permissible, but in some cases actually may be required by health planning laws.[13]

The Assembly Office did not consider other direct legislative controls such as those outlined above. Instead it offered suggestions on reimbursement for heavy-care residents, on changes in health planning criteria, and on alternatives to nursing home placement, all of

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which were designed to open up the market and decrease both motives and opportunities for discrimination.

4. The state has an obligation to ameliorate Medi-Cal discrimination.

This Commission concludes that, to the extent that Medi-Cal discrimination is a phenomenon largely caused by state policies, the state is under an obligation to remedy its causes and to protect its victims. In addition to change in market forces resulting from recommendations in Section A above, direct prohibitions are essential.

Recommendations

1. Requirement that facilities reveal Medi-Cal policies in advance

The Department should promulgate a regulation requiring that all facilities reveal to applicants, in writing and in advance of admission, whether the facility participates in Medi-Cal, and if so, the circumstances under which the law and the facility's policy permit a Medi-Cal recipient to be transferred involuntarily. Ultimately, this requirement should be part of any nondiscrimination statute enacted by the legislature.

2. Prohibition on transfer because of conversion to Medi-Cal

If the Attorney General finds that eviction of Medi-Cal converters is permissible under current law, the legislature should protect residents by enacting a statute that states:

> No resident shall be transferred as a result of a change in status from self-pay or Medicare to Medi-Cal provided the facility participates in the Medi-Cal program.

There should be opportunity for a hearing prior to any involuntary transfer, to determine whether the transfer is legal. Also, facilities should be required to reveal Medi-Cal policies, as outlined in Recommendation 1.

3. Adequate mandatory bed-hold for hospitalized Medi-Cal residents

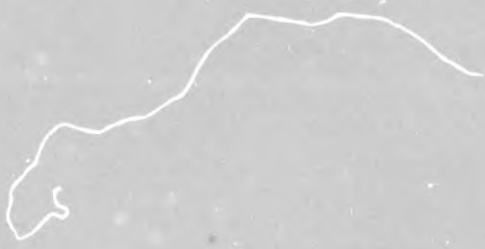
The legislature should require, and provide funds to pay for, retention of Medi-Cal beds during acute hospitalization, for long enough to prevent evictions based on relatively brief medical absence. That time period is longer than three days, and is probably more on the order of fifteen days.

4. Statute prohibiting all forms of Medi-Cal discrimination

In view of the extent of general Medi-Cal discrimination, plus the potential for complex tactics to avoid obligations toward residents who convert, a more comprehensive antidiscrimination policy is essential. The special Task Force proposed in Section A, Recommendation 4, should factor into its considerations the necessity for, and effects of, such a policy.

This Commission recommends that the legislature adopt the Ohio approach (Appendix VII-A), where all beds in a Medicaid-participating facility must be covered under its provider agreement, and where there may be no discrimination in either admissions or transfers. That means first come, first served, regardless of race, color, sex, creed, national origin, or source of payment. As in Ohio, exceptions would be permissible so that life care, denominational, and county facilities could give preference to their members or constituents.

If any quota approach is adopted, it should be based first on retention of current residents who convert, regardless of whether this puts the facility over its quota. Additional residents would be accepted if the quota remained unfilled.



From State of Florida, Annual Report of the Long-Term Ombudsman Council 1983.

Illustrative Problems in Access to Nursing Home Care

Even though the Legislature in 1983 appropriated over $20 million to provide higher reimbursements to nursing home providers willing to accept publicly-funded individuals, access to nursing home care is still primarily available only for those who can pay the private rates:

> But those who can't pay $1,500 to $3,000 a month [for care] are at the mercy of Medicaid--and that's not a very popular word with nursing home administrators.
>
> The county's [Broward] ever-increasing number of frail elderly people find few nursing homes eager to accept the state funds that take over when private savings run out.
>
> In every way, money determines your options. The more you can pay, the better care you get.... When you're old and helpless, it seems so much more horrifying.
>
> Nothing requires private nursing homes to accept Medicaid patients. Nursing home administrators insist that nothing encourages them to.[8]

Individual examples in the article cited above from the Miami Herald, Broward County edition, included that of an 87-year-old man who spent $70,000 for three years of care in a private nursing home who was told he must leave when his funds were depleted.

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Another man and his wife, both 80 years old, were told that the only way the husband would be accepted as a Medicaid resident is if they paid private rates for a year, first. This would exhaust their savings and is, in fact, a violation of state Medicaid regulations.

Yet another Miami Herald newspaper article pointed out that on one day, twenty elderly patients languished in $550-a-day beds at Jackson Memorial Medical Center, more than ten times the cost of nursing home care, because there were no beds available, especially for Medicaid recipients.[9] Another thirty elderly persons were waiting at home for placement. The director of the state's Long-Term Care Project in Miami noted that at any given moment forty to fifty people are on the Medicaid waiting list for a nursing home.[10] Jackson Memorial's social service director noted that the average unnecessary hospital stay for a patient waiting for a nursing home bed is two weeks, although private patients can usually be placed in one day.[11]

In November 1983, the St. Petersburg Times reported the case of an elderly woman, incontinent and unable to care at all for herself, who was discharged to the care of her 74-year-old husband who had suffered three heart attacks. No nursing home would accept her because of her Medicaid payment status.[12] As the General Accounting Office report noted, and as this case illustrated, recently initiated federal hospital reimbursement plans, which encourage early discharge of hospital patients, will exacerbate the existing problems of access especially for "heavy care" Medicaid recipients.[13]

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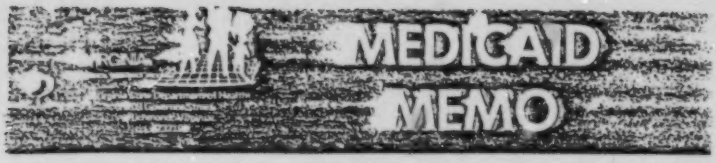

TO: All Hospitals and Nursing Homes Participating in the Virginia Medical Assistance Program

FROM: Robert J. Trasbley, Acting Director
Virginia Medical Assistance Program

MEMO	H - 57 NH - 57
DATE	4/21/80

SUBJECT: Preconditions for Admission or Continued Stay in Medical Facilities - Clarification of Medicaid Policies

The right of Medicaid recipients to receive medical facility services is based upon medical necessity and a determination of eligibility by the local departments of social services in Virginia. Additional requirements, such as prior status as a private paying patient, a pre-admission deposit, gifts, donations, or other considerations may not be established by a participating provider as a precondition for admission or as a requirement for continued stay in a facility.

Federal regulations (42CFR 450.30 (a) (8)) provide that "Participation in the program will be limited to providers of service who accept as payment in full, the amounts paid in accordance with the fee structure." Section 4 of Public Law 95-142 (The Medicare - Medicaid Antifraud and Abuse Amendments of 1977) quoted below provides that certain actions by facilities constitute a criminal act.

"Whoever knowingly and willfully (1) charges, for any service provided to a patient under a State plan approved under this title money or other consideration at a rate in excess of the rates established by the State, or (2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this title any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient) (A) as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or (B) as a requirement for the patient's continued stay in such a facility, when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan, shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both."

Appendix D

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Medicaid policy addresses three specific situations:

1. The Patient Is Medicaid Eligible at the Time of Admission

   If a patient is admitted to a Medicaid enrolled provider, there can be no precondition for admission requiring any period of private pay or a deposit from the patient or any other party.

2. Medicaid Eligibility Is Pending at the Time of Admission

   If a Medicaid enrolled provider is aware that an application for Medicaid eligibility is pending at the time of admission, Medicaid payment must be accepted from the first day of eligibility. Reimbursement must be made to the patient or any other party for any monies contributed toward the patient's care from the date of eligibility. The only exception is a situation in which a patient is spending down excess resources to meet eligibility requirements. The MAP - 122 will demonstrate the date from which the Virginia Medical Assistance Program must be billed.

3. A Private Pay Patient Applies for Medicaid and Becomes Eligible After Admission

   An enrolled provider may not require discharge of the patient or continue to require a period of private pay subsequent to the initial eligibility date for patients in Medicaid certified units. The Virginia Medicaid Program must be billed for all covered services delivered by a provider beginning with the date of eligibility in such cases. (42CFR 442.311 and 405.121, § 321.1 - 138 Code of Virginia, 1950 as amended)

NOTE: Nothing in this memo is to be construed to alter Virginia Medical Assistance Program policy concerning nursing home pre-admission screening contained in Medicaid Memo NH - 36, dated April 8, 1977.

Should you have any questions, please contact your area Program representative.

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RECEIVED JUL 16 1982

July 7, 1982

Lawrence R. Payne, Director
Medical Assistance Compliance Administration
Office of Medical Care Programs
201 W. Preston Street
Baltimore, Maryland 21201

Dear Mr. Payne:

You have requested our advice regarding the legality of several practices alleged to be engaged in by certain nursing home operators. You have also requested our advice regarding possible courses of action for the Medical Assistance Program ("Program") in addressing these practices. Specifically, the practices you have questioned are the following:

1. Requiring individuals and/or their families to sign a contract agreeing to remain as private pay patients for at least one year before seeking medical assistance eligibility;

2. Requiring individuals and/or their families to supplement medical assistance reimbursement as a condition for admission or continued residence in the home;

3. Encouraging individuals and/or their families to make contributions to nursing homes as a precondition of admission; and,

4. Threatening to discharge Medicaid recipients on grounds unrelated to medical necessity or nonpayment.

Each of these issues will be addressed in turn.

Background of the Problem:

You have indicated that there are currently 194 licensed nursing homes in the State of Maryland. This corresponds to 22,172 licensed beds.

Of these 194 facilities, 184 actually participate in either

the Medicare or Medicaid programs or in both. The total number of beds available to serve this population is 20,770.

The Medicaid patient census during the month of March, 1982 was 13,428. This means that Medicaid recipients occupied more than 64% of the available beds, or nearly 61% of the total licensed beds in the State.

Despite the substantial Medicaid nursing home population, Medicaid recipients often experience difficulties in obtaining access to available beds. Many recipients spend long months on waiting lists for nursing homes in their area or must accept admission to nursing homes far away from friends and relatives. Many homes prefer to admit private pay patients over Medicaid recipients because of the higher amounts that can be charged to these patients.

As indicated more fully herein, the fourth practice described above will have only a limited impact on Medicaid patients in nursing homes. However, the first three practices will adversely affect many Medicaid recipients.

For example, many nursing homes apparently require potential patients to agree to pay private pay rates for one year. Potential or current Medicaid recipients without outside incomes or sufficient resources or without relatives with sufficient income and resources may be unable to pay these private pay rates for even one month. Thus, these impoverished individuals will frequently be unable to secure admission to an appropriate facility despite the existence of a medical condition requiring institutional treatment. By contrast, wealthier individuals can effectively buy admission to a nursing home through this practice.

As explained in the following discussion, these four practices and their resulting discriminatory effects violate federal and/or state law. The Medical Assistance Program can and should take effective action to remedy these abuses.

Discussion:

1. Nursing home operators may not require individuals and/or their families to sign contracts agreeing to pay private pay rates for a specified period before converting to medical assistance.

Section 1909(d)(2)(A) of the Social Security Act, 42 U.S.C. 1396h(d)(2)(A), provides that:

> Whoever knowingly and willfully . . . charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this title, any gift, money, donation, or other

> consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient) . . . as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility . . . shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

According to the instant allegations, certain nursing home operators are requiring prospective Medicaid patients and/or their families to sign an agreement committing them to pay private pay rates for a specified period (usually one year). The execution of this agreement is a precondition of admitting the patient to the facility. The only remaining element of section 1909(d)(2)(A) that must therefore be satisfied in order to establish a violation is whether this agreement constitutes a gift, money, donation, or other consideration.

Private pay rates for nursing facilities are not controlled by either state or federal law. By contrast, medical assistance reimbursement is limited by state and federal statutes and regulations to those reasonable costs recognized by law. As a result, private pay rates generally exceed the rates paid under the Medicaid program.

By requiring prospective medical assistance recipients to be private pay for a specified period, the nursing home is able to receive the higher, private pay rate for that period. The effect is to increase the level of reimbursement available to the home, a frequently substantial financial benefit. The nursing home operator is therefore receiving a benefit (additional reimbursement) while the patient incurs a detriment (agreeing to pay private rates). The element of consideration is therefore present and a violation of section 1909(d)(2)(A) is established.1/

1/ This advice of counsel letter does not address all of the possible circumstances that may arise with regard to pre-admission contracts. For example, some patients will never become Medicaid-eligible during their stay. Nothing in the Medicaid statute prohibits a nursing home from requiring such an individual to agree to pay a certain dollar amount for a specified period of time. Moreover, in the case of a private pay patient who converts to Medicaid during the initial twelve months, the contract is not necessarily void ab initio. The contract would be unenforceable for any period of time after the person becomes Medicaid-eligible.

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The Regional Attorney of the United States Department of Health and Human Services has confirmed that this conduct violates section 1909 of the Social Security Act. This position was first stated to the Office of the Attorney General in 1980 and was reiterated in 1982. (Copies of these federal position statements have been attached for your consideration.) Since that time this Office has been reviewing this problem to determine available remedies.

Apparently some question has been raised regarding the extent to which Article 43, section 565C(a)(18)(v) of the Annotated Code of Maryland may authorize the conduct complained of herein. Section 565C(a)(18)(v) provides that, "An admission contract of a Medicaid certified facility may not require a patient to remain a private pay patient for more than 12 months as a condition for remaining in the nursing home in the event the patient becomes Medicaid eligible." Section 565C(a)(18)(v) therefore arguably authorizes, but does not require, nursing homes to utilize private pay contracts of less than 12 months in duration.

Under the Supremacy Clause of the United States Constitution, any state statute that is inconsistent with a validly enacted federal law is void. Article VI, clause 2 of the United States Constitution provides that,

> This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

See Carleson v. Remillard, 406 U.S. 598 (1972); Townsend v. Swank, 404 U.S. 282 (1971); Graham v. Richardson, 403 U.S. 365 (1971). This requirement is paralleled in Article 2 of the Declaration of Rights of the Constitution of Maryland. Thus, state law cannot authorize conduct prohibited by federal law. The provision of state law implicitly authorizing private pay contracts therefore cannot be given legal effect with regard to a nursing home participating in the Medicaid Program.2/

2/ The conclusion that this provision cannot be given legal effect with regard to nursing homes that participate in the Medicaid Program was recently emphasized in our bill review letter to Senate Bill 951 (1982). That legislation made the rights established under Article 43, section 565C(a)(18) applicable to patients in intermediate care facilities for the mentally retarded. With regard to the instant provision, our bill review letter explained that, "[I]t appears that the Legislature intended to authorize private pay contracts of up to (continued)

2. Nursing home operators may not require individuals and/or their families to supplement medical assistance reimbursement as a condition of admission or continued residence in the home.

42 C.F.R. 447.15 provides that, "A State plan must provide that the medicaid agency must limit participation in the medicaid program to providers who accept, as payment in full, the amounts paid by the agency." This provision is paralleled in the state regulations for nursing homes at COMAR 10.09.10.03I and 10.09.11.03E.

This prohibition on patient supplementation is further emphasized by the criminal sanctions established by section 1909(d)(1) of the Social Security Act. 42 U.S.C. 1396h(d)(1). This section provides that, "Whoever knowingly and willfully . . . charges, for any service provided to a patient under a State plan approved under this title, money or other consideration at a rate in excess of the rates established by the State . . . shall be guilty of a felony. . . ." This provision reaches supplementation sought from a patient, the patient's relative, or from any other person for a service covered under the medical assistance program.

There have already been prosecutions for conduct of the type alleged herein. In United States v. Zacher, 586 F.2d 912 (2d Cir. 1978), for example, the part-owner and administrator of a nursing home had been requiring patient families to pay the difference between the private pay rate and the Medicaid rate directly to the facility. Since this prosecution was brought prior to the enactment of section 1909(d), the conviction had to be reversed. However, the Court noted the enactment of the 1977 amendments to the Social Security Act and indicated that, "Our decision as to the criminality of Zacher's receipt of these payments under the old version of [section 1909(d)], while of great importance to Zacher, should have no impact on the liability of nursing home operators now receiving or soliciting similar payments." United States v. Zacher, supra, 586 F.2d at 913-914, n.3.

3. Nursing home operators may encourage voluntary contributions, but may not require contributions as a precondition of admission or continued residence in the home from patients or from persons related to patients.

Section 1909(d)(2)(A) of the Social Security Act, 42 U.S.C. 1396h(d)(2)(A), set forth in part one, establishes several specific conditions relating to the ability of providers to

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one year. To that extent, the provisions [sic] is inconsistent with federal law and cannot be given effect." (A copy of that bill review letter is attached for your consideration.)

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accept contributions. Pursuant to section 1909(d)(2)(B), 42 U.S.C. 1396h(d)(2)(B), these conditions are equally applicable to contributions sought as a requirement for a patient's continued stay in a facility when the cost of the services provided therein are paid for in whole or in part under the State plan.

First, contributions may not be charged, solicited, accepted, or received from patients or from persons related to patients when those contributions are sought as a precondition of admitting the patient to a facility or as a requirement for the patient's continued stay. Any such contributions must therefore be truly voluntary.

Second, charitable, religious, or philanthropic contributions may be charged, solicited, accepted, or received from organizations or from persons unrelated to patients even if those contributions are being sought as a precondition of admitting a patient to a facility or as a requirement for the patient's continued stay. However, under Maryland law, even if the contribution is not made, the facility cannot transfer or involuntarily discharge a current patient unless one of the other conditions in Article 43, section 565C(a)(18)(i) is met.

Third, contributions may be sought from any party for services that are not paid for in whole or in part by the Medicaid program. The longstanding regulatory requirement, that Medicaid reimbursement must be accepted as reimbursement in full, is only triggered when there is at least some Medicaid reimbursement for a service. See, 42 C.F.R. 447.15. See also, 42 U.S.C. 1396h(d)(1). Thus, contributions can be sought for such personal comfort items as televisions which are not covered in whole or in part under the Medicaid program.

4. Nursing home operators participating in the Medicare and/or Medicaid programs may not discharge residents on grounds that are not enumerated in 42 C.F.R. 405.1121(k)(4) and 442.311.

Federal regulations establish conditions of participation for nursing homes in the Medicare and Medicaid programs. One of these conditions requires nursing homes to establish written policies and procedures that insure that each resident will "be transferred or discharged only for - (1) Medical reasons; (2) His welfare or that of the other residents; or (3) Nonpayment except as prohibited by the Medicaid program." 42 C.F.R. 442.311(c); see also, 42 C.F.R. 405.1121(k)(4). Nursing homes that violate these conditions may not participate in the Medicare or Medicaid programs. 42 C.F.R. 405.1121, 442.250. Thus, no resident may be discharged from a nursing home participating in the Medicare or Medicaid programs except for one of the three authorized reasons.

Article 43, section 565C of the Annotated Code of Maryland establishes similar safeguards for nursing home residents in the State of Maryland. However, whereas the federal regulations protect only those residents living in nursing homes

participating in the Medicare and/or Medicaid programs, section 565C protects all patients regardless of the nature of the home.

Section 565C authorizes involuntary transfers or discharges for the three conditions permitted by federal law. In addition, section 565C authorizes involuntary transfer or discharge of a patient who violates "contract provisions by knowingly divesting himself of his personal assets for the sole purpose of receiving medical assistance." Ann. Code of Maryland, art. 43, §565C(a)(18)(i)(3). Since the federal regulations only reach nursing homes participating in the Medicare and/or Medicaid programs, the only question of possible inconsistency arises with regard to an attempted involuntary transfer or discharge of a resident in a Medicare and/or Medicaid certified home whose transfer or discharge is being sought solely on the basis that he knowingly divested himself of assets.

As discussed in part one, a review of the Maryland provision must necessarily start with a recognition that any state statute that is inconsistent with federal law is invalid under the Supremacy Clause. Thus, no patient in a Medicare and/or Medicaid certified home may be discharged except for one of the three reasons enumerated under the federal regulation. However, an examination of the state statute reveals that any inconsistency would be unlikely to arise.

Section 565C(a)(18)(i)(3) was added to Article 43 after the decision of the Court of Appeals for the Fourth Circuit in Fabula v. Buck, 598 F.2d 869 (4th Cir. 1979). That decision enjoined enforcement of the Maryland regulation that disqualified from medical assistance those persons who knowingly divested themselves of personal assets for the sole purpose of receiving medical assistance. A legislative amendment was therefore sought by the nursing home industry and enacted by the legislature in the third reading of H.B. 137 (1980) in order to discourage a significant number of private pay patients from transferring assets for the sole purpose of qualifying for medical assistance. This change assured that nursing homes could continue to receive the higher private pay rates for these patients for at least 12 months. Ann. Code of Maryland, art. 43, §565C(a)(18)(v).

In 1981, the United States Congress enacted an amendment to the Social Security Act that authorized states, for the first time, to penalize certain recipients who transferred assets in order to qualify for Medicaid. Pub.L. 96-611, sec. 5(b). These provisions are now contained in section 1902(j) of the Social Security Act, 42 U.S.C. 1396a(j).

Pursuant to this federal authorization, the Department of Health and Mental Hygiene adopted a regulation, effective November 1, 1981, that disqualified from medical assistance certain individuals who transferred assets in order to qualify

for Medicaid. COMAR 10.09.01.10D. Thus, any recipient who unlawfully transfers assets in order to qualify for Medicaid will be disqualified from the Program for up to two years. Such an individual will also be ineligible for Medicaid reimbursement of nursing home care and could then be transferred or discharged for nonpayment if no reimbursement is made to the home.

It is theoretically possible for some recipients to transfer assets, suffer a disqualification period, and then become eligible for Medical Assistance. The instant contract provisions could thereby come into play. However, federal law would prohibit a nursing home from transferring or discharging a patient under such circumstances despite the seeming authorization under state law.3/

5. Remedies

Three types of remedies are available to address the conduct complained of. First, criminal sanctions can be sought against providers who violate applicable criminal provisions. Second, civil administrative sanctions can be sought against providers who violate applicable rules of conduct. Third, civil judicial proceedings can be initiated against providers who engage in conduct that is prohibited by state or federal law.

a. Criminal Sanctions

In appropriate situations, criminal prosecutions can be initiated by either the Medicaid Fraud Control Unit, for conduct that violates state criminal laws, or by the United States Attorney, for conduct that violates federal criminal statutes. We note that the discretionary decision to prosecute would not likely be exercised where nursing homes engaged in a prohibited practice in a good faith misunderstanding as to applicable law, particularly where state law appeared to authorize the practice. However, these prosecution units may well be interested in pursuing cases of a more flagrant nature, particularly where the nursing home refused to conform its conduct to applicable law after receiving notification of the illegality of the conduct. We suggest below that such notification take place as soon as it is feasible to do so.

We recommend that you continue your practice of referring

3/ Senate Bill 951 also applied this provision to patients in intermediate care facilities for the mentally retarded. The bill review letter emphasized that, "Senate Bill 951 . . . cannot withdraw rights that are guaranteed by federal law. To the extent that it authorizes conduct that is proscribed by federal law, it cannot be given effect."

suitable cases to the appropriate prosecution units and that you confer with those units about whether referrals for prosecution in any particular class of cases is warranted.

b. Administrative Sanctions

The Department is required to monitor current policies and practices of providers and may invoke appropriate sanctions under state law. These sanctions are set forth in COMAR 10.09.10.16A. and 10.09.11.16A. as follows:

> If the Department determines that a provider, any agent or employee of the provider, or any person with an ownership interest in the provider has failed to comply with applicable federal and State laws and regulations, the Department may initiate one or more of the following actions against the responsible party:
>
> (1) Suspension from the Program;
>
> (2) Withholding of payment by the Program;
>
> (3) Removal from the Program;
>
> (4) Disqualification from future participation in the Program, either as a provider or as a person providing services for which Program payment will be claimed.

The Program therefore has various options as to possible sanctions against homes that continue to violate federal law.

In deciding whether or not to initiate administrative proceedings against a particular home, the Medical Assistance Compliance Administration may wish to consider the extent to which confusion regarding state law contributed to violations of section 1909(d) of the Social Security Act. Unlike the interface with criminal law, the regulations vest considerable discretion in your office to determine whether initiation of sanctions is appropriate.

The imposition of administrative sanctions to remedy past practices raises a difficult question. This office is not aware of any cases in this State in which sanctions, such as withholding of current reimbursement, have been imposed to make patients and their families whole. If you determine that an appropriate case exists for such an approach, we should review the various legal options available to the Program.

It appears that the conduct complained of may be widespread in the industry. In order to encourage maximum compliance with

the applicable requirements of law, your office may wish to consider sending a warning notice as a first step to all providers advising them of the illegality of the various practices. For those providers engaging in these practices in ignorance of federal law, this education effort may thereby discourage future violations.

The Office on Aging should also be advised of these possible violations of federal law in order to expedite notification to current patients and their families. This information might also be included in future recipient mailings from the Program.

The Medical Assistance Compliance Administration will also need to investigate complaints by recipients and families. Determining the factual basis for complaints may often be a difficult task. For example, with regard to encouragement of patient or relative "contributions" as a precondition of admission, your investigations may reveal that patients and/or their relatives are being led to believe that a contribution will facilitate or guarantee their admission.

In such cases, it may be necessary to go behind the express language contained on forms provided by a facility. While the literature provided by a facility may indicate that contributions are voluntary, in practice only those individuals who make contributions may be accepted from the waiting list. The Program will therefore need to review the admissions practices of facilities in addition to conducting interviews with patients and their families.

c. Civil Proceedings

In light of the availability of administrative sanctions, the Medical Assistance Program will generally not be involved in initiating civil proceedings against providers. However, patients and/or their relatives may seek to set aside existing contracts or to recover monies paid pursuant to unlawful private pay contracts. In such cases, the Medical Assistance Program may wish to intervene on the side of patients and their families as an amicus curiae, friend of the court, to discuss the relationship of federal and state law. The Office of the Attorney General is willing to participate in an appropriate capacity on behalf of the Program in any challenges to such contracts.

Conclusion:

We hope that this discussion adequately addresses the legal consequences of the conduct described in your request. Please

feel free to contact this office if you would like to discuss these issues further.

Very truly yours,

Stephen H. Sachs
Attorney General

David F. Chavkin
Assistant Attorney General

SHS/DFC:kaa

Dr. ELEANOR M. CAREY
DEPUTY ATTORNEY GENERAL
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THE ATTORNEY GENERAL
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90 STATE CIRCLE
ANNAPOLIS, MARYLAND 21401-1991
AREA CODE 301
BALTIMORE & LOCAL CALLING AREA 841-3888
WASHINGTON METROPOLITAN AREA 858-3888
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May 24, 1982

The Honorable Harry Hughes
Governor of Maryland
State House
Annapolis, Maryland 21404

Re: Senate Bill 951

Dear Governor Hughes:

This office has reviewed for constitutionality and legal sufficiency Senate Bill 951. This bill would define certain limited circumstances under which patients in intermediate care facilities for the mentally retarded could be involuntarily transferred or discharged. Although the bill may be signed into law, two provisions of the legislation conflict with federal law and, because of the Supremacy Clause of the U. S. Constitution, must be applied in accordance with federal law.

The first provision is found in the amendment enacting Section 7-709(B)(3). This provision authorizes intermediate care facilities for the mentally retarded (ICF/MR) to involuntarily transfer or discharge a patient who knowingly transfers personal assets in violation of contract provisions and only to become eligible for medicaid benefits.1/

1/ This provision was modeled after a provision in the Health-General Article, §19-345 (former Article 43, §565C(a)(18)(i) 3.) that defines the rights of patients in skilled nursing facilities and intermediate care facilities. This provision raised similar problems under federal law and was the subject of a previous bill review letter regarding House Bill 137 (1980). That provision was enacted in the wake of a United States District Court decision invalidating the Maryland prohibition on transfers of assets. Since that time, federal law has been changed to authorize such prohibitions and a new State regulation was promulgated last year.

All patients in skilled nursing facilities, intermediate care facilities, and intermediate care facilities for the mentally retarded have certain rights under federal law. These rights are known generically as the Patients' Bill of Rights. 42 C.F.R. 442.404(c) defines the circumstances under federal law when patients can be involuntarily transferred or discharged. The only circumstances permitted under this section are transfers or discharges for medical reasons, for the welfare of the patient or the welfare of other residents, or for nonpayment. Violation of contract provisions on transfers of assets are not a permissible basis for transfer or discharge.

We are left then with a bill provision that expressly authorizes conduct that is prohibited under federal law. There is a slight difference in the scope of the State bill and the federal regulations. The federal regulations protect all patients in all facilities that receive either Medicare or Medicaid reimbursement. The State bill would apply to all patients in all facilities. As a practical matter, however, the scope of the two provisions would be coextensive.

Pursuant to Article VI, Clause 2 of the United States Constitution and Article 2 of the Maryland Constitution, this federal law must control as the supreme law of the land. The instant provision of Senate Bill 951 therefore cannot withdraw rights that are guaranteed by federal law. To the extent that it authorizes conduct that is proscribed by federal law, it cannot be given effect.

The second problem in the bill concerns the language contained in Section 7-709(D)(1)(I). This provision prohibits contractual provisions that require patients to remain as private pay patients for longer than one year. Conversely, it implicitly authorizes similar contractual provisions requiring patients to remain as private pay patients for up to one year.

Section 1909(d) of the Social Security Act prohibits facilities participating in the Medicaid program from requiring such pre-admission contracts. This office has been advised on two occasions of the illegality of this conduct (see attached letters) and has advised the Department of Health and Mental Hygiene of this analysis. Moreover, in the near future, this office will be advising all nursing homes operating in the State of Maryland of the criminal penalties applicable to those persons who require patients and/or their families to sign such contracts.

Senate Bill 951 would not mandate facilities to require such private pay contracts. We therefore do not have a direct

violation of federal law. However, it appears that the Legislature intended to authorize private pay contracts of up to one year. To that extent, the provisions is inconsistent with federal law and cannot be given effect.

In conclusion, it appears that this bill was intended to limit presently permitted practices and thereby protect patients from certain abusive conduct. To the extent the bill does so, not inconsistent with federal law, these provisions may be given effect if the bill is signed into law. However, those provisions discussed above which limit the rights of patients conflict with federal law and may not be given effect.

Very truly yours,

Stephen H. Sachs
Attorney General

SHS/DFC:ipb

cc: Carl Eastwick, Esq.
F. Carvel Payne
Hon. Fred L. Wineland
Hon. Melvin Steinberg

JOHN SPELLMAN
Governor

ALAN J. COBB
Secretary

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Olympia, Washington 98504

August 19, 1983

BNHA-883-1

Dear Nursing Home Administrator:

The purpose of this letter is to inform you of the Department of Social and Health Services' understanding of the legal implications surrounding two important issues. The first issue is the practice of requiring individuals seeking nursing home care and/or their families to sign contracts agreeing to pay as a private patient for a specified period of time before allowing them to convert to medical assistance. Depending upon the status of the patient to vis-a-vis his Medicaid eligibility, this practice may be contrary to both federal and state law.

Section 1909(d)(2) of the Social Security Act, 42 U.S.C., subsection 1396h (d)(2), provides:

> Whoever knowingly and willfully--
>
> (2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this title, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to that patient)--
>
> (A) as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or
>
> (B) as a requirement for the patient's continued stay in such a facility, when a cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan
>
> shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both. [Emphasis added; SSA enclosed.]

RCW 74.09.260(2) is the equivalent of the federal law and prohibits this practice on the state level. (RCW enclosed.)

Therefore, an individual who is eligible for medical assistance, or his relatives, cannot be required to sign an agreement which compels payment as a private patient as a condition for entering the nursing home. Such a requirement would entail the receipt of, or solicitation for, additional consideration as a precondition of admission.

In Washington, private pay rates for nursing facilities are not controlled by either state or federal law; they are negotiated between the private parties. By contrast, medical assistance reimbursement is limited by state and federal statute and regulations to reasonable costs incurred by economically and efficiently operated facilities. As a result, private pay rates generally exceed the rates paid under the Medicaid program.

By requiring prospective medical assistance recipients to pay private patient rates for a specified time period, the nursing home seeks to receive the higher rate. This increases the level of revenue available to the home. The nursing home may therefore be receiving a benefit in the form of additional revenue while the patient incurs a detriment by agreeing to pay private rates. The element of consideration is therefore present, and a violation of either or both statutes may be established by the solicitation or agreement.

Individuals not eligible for medical assistance at the time of entering the nursing home facility can be required to pay private pay rates at the outset. However, as soon as the individual is determined eligible for medical assistance, they can no longer be required to pay private rates under the contract. By statute, the contract becomes void at the time the individual is determined eligible for Medicaid. These statutes also apply to contracts between the facility and a patient's relatives. The home may only accept Medicaid reimbursement under the state plan as payment after the patient becomes eligible for assistance.

An individual who has sufficient assets which would preclude future eligibility for Medicaid, can be required to sign a contract requiring payment as a private patient. Nothing in the Medicaid statute prohibits a nursing home from requiring such individuals or relatives to agree to pay a certain dollar amount for a specified period of time.

A second and related Medicaid discrimination issue is a contractor's right to refuse the admission of a medical assistance patient. The terms and conditions of the provider contract on page 2, under the heading "Contractor's Right to Accept or Reject Recipient," states: "The Contractor shall have the right to refuse to admit any recipient when the Contractor has determined that the recipient's needs cannot be met by the Contractor."

This provision of the contract makes clear that the contractor's only right of refusal to admit a Medicaid patient is when the provider determines that the patient's needs cannot be met by the provider. The provider may not refuse to admit a Medicaid patient solely on the grounds that the patient is a medical assistance recipient.

Should you have questions regarding Medicaid discrimination, please contact Sharon Morrison, Manager, Program Integrity Unit, at (206) 754-1643.

Yours truly,

Conrad Thompson, Director
Bureau of Nursing Home Affairs

CT:SM:th

cc: Gerald Reilly, Director, DHA
Allen Miller, AAG
Sharon Morrison

Enclosures - Social Security Act
Section 1909(d)(2)
RCW 74.09.260(2)

RCW 74.09.260 Excessive charges, payments—Penalties. Any person, including any corporation, that knowingly

(1) charges, for any service provided to a patient under any medical care plan authorized under this chapter, money or other consideration at a rate in excess of the rates established by the department of social and health services, or

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under such plan any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)

(a) as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or

(b) as a requirement for the patient's continued stay in such facility,

when the cost of the services provided therein to the patient is paid for, in whole or in part, under such plan, shall be guilty of a class C felony: *Provided*, That the fine, if imposed, shall not be in an amount more than twenty-five thousand dollars, except as authorized by RCW 9A.20.030. [1979 ex.s. c 152 § 7.]

(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; and

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facility, or home health agency (as those terms are employed in this title) shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(d) Whoever knowingly and willfully—

(1) charges, for any service provided to a patient under a State plan approved under this title, money or other consideration at a rate in excess of the rates established by the State, or

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this title, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)—

(A) as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or

(B) as a requirement for the patient's continued stay in such a facility,

when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan,

shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

418 2-84

¶ 33,605 NEW YORK—REIMBURSEMENT FOR NURSING HOME SERVICES—MEDICAID PAYMENT AS PAYMENT IN FULL

Glengariff Corp. v. Snook, et al. New York Supreme Court, Nassau County, Special Term, Part I. No. 2143/83, Jan. 4, 1984.

Nursing home reimbursement—Medicaid rate as payment in full—Supplementation by relative—Contract.—A provider of Medicaid services is required, by both federal and New York law, to accept the payment under Medicaid as payment in full. Therefore, a nursing home could not solicit additional payment from the son of a recipient even though, before his mother applied for and was granted Medicaid benefits, he had signed a contract agreeing to pay the full private room rate. This case involves matters of public policy—the right of a poor person to apply for Medicaid and the general prohibition against "supplementation" of nursing home payments by relatives and friends—and, in such an instance, a statute or regulation supporting the policy cannot be waived if it conflicts with the terms of a contract. *Back references:* ¶ 14,723, 14,755.29, 15,620.

[Footnote at end of decision]

BURSTEIN, Judge: This case, apparently one of first impression, involves the scope of a federal statute and regulation and a counterpart state regulation, each of which essentially requires that payments received from Medicaid by a provider of services shall be accepted as payment in full.

Plaintiff seeks summary judgment, pursuant to CPLR 3212, claiming there are no issues of fact, or, in the alternative, for an order dismissing defendants' affirmative defenses, pursuant to CPLR 3211(b), on the ground they have no merit. Defendants cross-move for an order, pursuant to CPLR 3025(b), granting them leave to amend their answer so as to assert the affirmative defense of payment, and based thereon, they seek an order dismissing plaintiff's complaint, pursuant to CPLR 3211(a)(5). Leave to amend is granted. The Court hereby deems the answer amended so as to include a seventh affirmative defense of payment, as set forth in the proposed amended answer contained in the cross-moving papers. The Court now considers whether either summary judgment or the dismissal defendants seek will lie.

[Facts]

The following facts are uncontroverted. Plaintiff operates a private licensed nursing home and, at all relevant times, was a participant in what is commonly known as the Medicaid program.

Defendant Margaret Snook is a patient in plaintiff's nursing home. Prior to her admittance, plaintiff's representative met with her son, defendant Robert Snook (hereinafter defendant). The representative avers, on personal knowledge, that defendant said he would prefer to pay more to have his mother in a private room rather than a semi-private room. At that time, defendant Margaret Snook was not receiving any public assistance. Three days later, on July 10, 1982, Margaret Snook entered the home as a private patient. On that date, defendant signed an agreement as "Sponsor," which provided, *inter alia*, that:

> 1. The Glengariff Corporation hereby admits the Patient to the Facility. In consideration, the Patient and Sponsor *agree* to pay The Glengariff Corporation its basic charge for the basic facility services furnished (itemized in the following paragraph 2) at the current daily basic rate of $95.60 for a *PRIVATE* room, or at such increased basic rate that shall comply with paragraph *6* below.
>
> • • •
>
> Patient and Sponsor acknowledge and agree that the Glengariff Corporation ... not obligated to accept Medicaid payments in lieu of the private payments from the Patient and Sponsor required hereunder unless and until (a) the Patient shall have been a patient in the Facility for a period of at least *18 months* and (b) the Patient and Sponsor shall have paid in full all sums due The Glengariff Corporation hereunder from the Patient and Sponsor for all periods prior to the first actual receipt of such Medicaid payments and shall have performed in full all of the obligations under this agreement on their part to be performed during such periods. The Glengariff Corporation will credit against the sums due The Glengariff Corporation hereunder from the Patient and Sponsor any reimbursements actually received from Medicare for Facility services and items furnished by The Glengariff Corporation to the Patient. ..."

Appendix G

128

39-718 O 84 - 9

From State of New York Department of Health Memorandum, Questions and Answers Pertaining to Written Admissions Agreements Between Residential Health Care Facilities and Patients/Residents, Series 84-54 (June 13, 1984).

NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF HEALTH SYSTEMS MANAGEMENT

ADMISSIONS AGREEMENTS - Questions and Answers[1]

GUARANTEES OF PRIVATE PAY FOR A SPECIFIED PERIOD OF TIME PROHIBITED

1. May a facility enforce an admissions agreement which requires that a patient and/or family member "guarantee" a certain period of private pay stay even though the patient becomes Medicaid eligible and/or a Medicaid recipient within that time period?

Answer - No.

Section 2805-f(4) of the New York State Public Health Law (Chapter 716 of the Laws of 1982) and corresponding Federal law [Section 1909(d) of the Social Security Act; 42 USC 1396 h(d) (1977)] state that any operator who knowingly and willfully charges money or other consideration for any service provided to a Medicaid recipient "in excess of" the Medicaid rate as a requirement for the recipient's continued stay in such facility is guilty of a felony. The above laws also state that it is a crime for an operator to charge or solicit money or other consideration in excess of the Medicaid rate as a precondition for admission to the facility.

Section 2805 f(4) of the New York State Public Health Law exempts charitable, religious, or philanthropic contributions made voluntarily by the recipient.

Federal and corresponding State laws require that all providers participating in the Medicaid program accept Medicaid payments as payments in full for the cost of services provided to program recipients. Federal regulation (42 CFR 447.15) provides that:

> "A State plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency (emphasis added)."

This requirement is repeated in State Social Service regulations [18 NYCRR Sections 360.27 and 540.7(a)(8)] for all New York State Medicaid providers.

[1]Except as otherwise stated, all Code citations are from Title 10 of New York State Code, Rules, and Regulations (10NYCRR).

Appendix G
(continued)

Also, Section 414.14(a)(4) of Department of Health regulations states that

> "The patients' and residents' rights, policies and procedures shall ensure that, at least, each patient and resident admitted to the facility:
>
> (4) is transferred or discharged only for medical reasons, or for his welfare...or for non-payment for his stay (except as prohibited by sources of third-party payment)...(emphasis added)."

Therefore, if during the period of time in which the patient is required to remain private pay, the patient "spends down" and can no longer pay the private pay rate, the patient may be eligible for Medicaid. Once a patient applies to be and is certified as a Medicaid recipient, an operator may not continue to insist that a patient pay the higher private pay rate as a condition of the patient's continued stay in the facility. An operator may not also attempt to collect the difference between the private pay rate and the Medicaid rate in accordance with an admissions agreement covered by the aforementioned Federal and State statutes. Such activity would be viewed as charging an amount in addition to the Medicaid rate as a pre-condition for continued stay in the facility. Such action may be considered criminal activity.

Attempts to discharge patients who convert to Medicaid before the lapse of time specified in the admissions agreement are similarly illegal. Section 414.14 of Department regulations as indicated above states that patients may be involuntarily discharged only for, among other reasons, non-payment of stay. Residential health care facilities participating in Medicaid have agreed to accept Medicaid payment as payment in full. Therefore, conversion from private pay to Medicaid does not constitute non-payment of stay.

Clauses in admissions agreements which constitute "waivers" of the rights of patients enumerated in Section 414.14 of Department regulations or of the right of a patient to apply for Medicaid are void since they are contrary to the public policy of this State. The rights of patients contained in Department of Health regulations are absolute legal obligations owed to the patient and to the State as a condition of facility licensure and participation in the Medicaid program. Such rights may not be waived.

May an operator of a residential health care facility require a prospective private pay patient and/or sponsor as a condition of admission to the facility to sign an admission agreement requiring payment of the private pay rate for a specified period of time before the patient can convert to Medicaid coverage?

Answer - No.

Section 2803-c of the Public Health Law states that every nursing home in this State shall adopt and make public a statement of the rights and responsibilities of patients in the facility and shall treat patients in accordance with such rights. Section 2803-c(3)(a) of the Public Health Law states that every statement of rights shall include the following provision:

> "(a) Every patient's civil...liberties including the right to independent personal decisions and knowledge of available choices, shall not be infringed and the facility shall encourage and assist in the fullest possible exercise of these rights (emphasis added)."

In addition, Section 414.14(a) of Department of Health regulations, paragraphs (1) and (4), state that:

> "The patients' and residents' rights, policies and procedures shall ensure that, at least, each patient and resident admitted to the facility:
>
> (1) is fully informed. .of these rights...
>
> (4) is transferred or discharged only for medical reasons, or for his welfare...or for non-payment for his stay (except as prohibited by sources of third-party payment)... (emphasis added)."

Patients have a right to apply for Medicaid when their funds are exhausted. With regard to payment, patients have a right to be discharged only for "non-payment" of stay. Facilities with a Medicaid provider agreement have agreed to accept Medicaid payment as "payment in full" for provision of services.

Therefore, clauses in an admissions agreement which require private pay status for a specified period of time are void at the time the admissions agreement is signed since they do not correctly inform the patient of his/her rights (e.g., the right of a patient to apply for Medicaid when funds are exhausted and that a facility with a Medicaid provider agreement has agreed to accept Medicaid payment as "payment in full").

Such clauses not only fail to fully inform patients of their rights but also mislead patients. The clauses mislead patients into believing that during the time specified in the admissions agreement, despite eligibility, the patient is prevented from applying for Medicaid. For this additional reason, such clauses may not be inserted in admission agreements.

Patients' rights may not be waived. Attempts by facilities to collect the private pay rate at the time a patient becomes a Medicaid recipient may constitute criminal activity (see Answer to Question 1 above).

PAYMENT ISSUES

3. Must the admissions agreement be the vehicle to specify the amount and duration of any prepayment?

Answer - No.

The admissions agreement may, but does not have to, specify the amount and duration of any prepayment. However, there must be some written document containing the prepayment amount.

Section 414.14(a)(2) requires a written statement of related charges and charges "not covered by the facility's basic per diem rate." If the admissions agreement is the vehicle for this information, it must specify the amount and duration of prepayment. Under Section 415.1(f)[420.1(f)-HRF], the prepayment amount cannot exceed three months.

4. May an admissions agreement state that patients are charged an "admission fee" to guarantee room availability as of a specific date?

Answer - No.

Under Section 414.14(a)(2), a patient must be given a written statement of related charges and charges "not covered by the facility's basic per diem rate." Though this is a written statement of such a charge, under Section 414.16(c)(2), no operator may request any remuneration, tip or gratuity <u>in any form</u> from a patient for any services provided or arranged "...other than specified fees ordinarily paid for care, excluding donations, gifts and legacies given in behalf of the facility." Therefore, an "admission fee" which will not be applied towards the basic rate is prohibited. On the other hand, a charge that was applied towards the basic rate (e.g., room reservation charge) would be acceptable if, as indicated in Section 415.1(f)-SNF [420.1(f)-HRF] the prepayment amount does not exceed three months.

5. May the admissions agreement specify that there is a fee for late payment of charges or that the patient may be discharged due to non-payment of charges?

Answer - No for Medicaid patients - Section 414.14(a)(4) expressly prohibits such charges or discharges.

- Yes for private paying patients only:

Fees for Late Payment - Section 414.14(a)(2) requires a written statement of related charges and charges "not covered by the facility's basic per diem rate." Under Section 415.1(g)(1)-SNF [420.1(g)(1)-HRF], the operator may assess no additional charges in excess of the basic rate except "upon express written approval and authority of the patient, next of kin, or sponsor." Therefore, as long as the charge for the late payment is contained in a written agreement between the operator and the patient, it is not in violation of the Code. The charge need not be specified in the admissions agreement but must be specified in a written agreement. State usury laws apply to such charges.

Patient Discharge Due to Non-payment - Section 414.14(a)(4) states that a patient may be discharged for non-payment. However, Department regulations also indicate that the facility must conduct appropriate discharge planning that meets the needs of the patient prior to any discharge (Sections 416.9-SNF, 421.13-HRF).

6. May an admissions agreement require that a patient apply for Medicaid should the patient's finances be depleted?

Answer - Yes.

A facility is required to apply to Medicaid for the patient or the patient may choose to do the application. However, if the patient chooses not to apply or not to allow the facility to apply and private funds are exhausted, the patient may be discharged for non-payment of stay [see Section 414.14(a)(4)] with appropriate discharge planning.

7. May an admissions agreement contain a provision that relatives of the prospective patient agree that in the event the patient is ultimately denied Medicaid, the relative signing the agreement would be liable for the charge incurred from the date of admission?

Answer - Yes (with qualifications).

This is acceptable if the term "charges" is meant to mean basic rate for care and provided that the family members know to what they are agreeing, i.e., whether it be the basic rate or additional charges. The only way a facility can assure that the family members are fully aware of their liability for charges incurred from the date of admission is for the agreement to clearly specify that liability.

MAY 29 1981

Mr. B. P. Simmons
Director
Mississippi Medicaid Commission
P. O. Box 16786
Jackson, Mississippi 39205

Dear Mr. Simmons:

The Health Care Financing Administration has carefully reviewed your proposed title XIX State plan amendment (Transmittal No. 80-7) to limit the number of Medicaid nursing home beds in Mississippi to 100 beds per 1,000 Medicaid eligibles. We have decided that this amendment cannot be approved because it conflicts with various statutory and regulatory requirements.

Under the requirements governing provider agreements with certified facilities (42 CFR 442.12(d)), a State must either enter into a provider agreement for all certifiable beds in the facility or decline to enter into a provider agreement for "good cause." The State does not have the option of denying a proportion of beds in all facilities. Moreover, implementation of the proposed amendment would result in individuals being denied access to certified beds, even if they are empty. This could ultimately lead to waiting lists for otherwise available beds, which would violate section 1902(a)(8) of the Social Security Act, requiring that medical assistance "be furnished with reasonable promptness to all eligible individuals." Finally, the amendment, if approved, would create a situation in which some individuals would receive full coverage in a nursing home while others of equal or more urgent need would arbitrarily be denied the benefit or would be delayed in receiving the benefit as a consequence of where they reside in the State. Such a situation would violate the regulatory requirement for sufficiency of amount, duration, and scope in 42 CFR 440.230:

> ". . . (b) Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose. . .
>
> "(c)(2) The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures."

Appendix H

Accordingly, after consultation with the Secretary, as required by 45 CFR 201.3(c), I am hereby disapproving limitations No. 4a, 15, and 17d contained in State Plan Transmittal No. 80-7. We are quite willing to work with the State, however, to resolve the problems inhibiting effective control of utilization and nursing home capacity. Also, if legislation providing greater State flexibility in Medicaid program administration is enacted, we would be willing to reconsider the State's bed limit proposal under the new statutory provisions.

Reconsideration of this decision may be requested pursuant to the provisions of section 1116(a)(2) of the Social Security Act and regulations issued at 45 CFR 201.4.

If you have any questions regarding our decision, please contact James Yates, Acting Regional Administrator of the Health Care Financing Administration in Atlanta, Georgia.

Sincerely yours,

Carolyne K. Davis

Carolyne K. Davis, Ph.D.

BEST COPY AVAILABLE

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Memorandum

Date AUG 8 1983

From Director
Bureau of Eligibility, Reimbursement and Coverage

Subject Freedom of Choice Issues Involving Long-Term Care Providers (Your Memorandum Dated April 28, 1983)--POLICY INFORMATION FOR ALL REGIONS

To Regional Administrator
Region IV, Atlanta
Attn: Policy & Technical Assistance Branch
Division of Program Operations

This is in response to your memorandum requesting policy clarification with respect to freedom of choice issues involving long-term care providers. As you note, this issue was brought to your attention by two State Medicaid agencies in their inquiry concerning the freedom of nursing homes to deny admission to Medicaid recipients.

Our response to the specific questions raised by the two State Medicaid agencies are as follows:

Question 1

Can a nursing home that has a vacancy deny admission of a Medicaid patient in need of nursing home care?

Response

Yes. We concur with your position that admission of a Medicaid patient in need of nursing home care can be denied if the denial is not in violation of the Civil Rights Act. According to section 1902(a)(23) of the Social Security Act, the "freedom of choice" provision, a State plan is required to provide "that any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required . . . who undertakes to provide him such services . . ." (emphasis added).

In the situations raised by question 1 (e.g., if the recipient's needs cannot be met by the institution) the recipient has no statutory right of admission under the freedom of choice provision of the Act. We have been advised by the Office of the General Counsel (OGC) that two parts of the statute may reasonably be interpreted to reach this conclusion. First, the provider has not "undertaken to provide him such services," i.e., is not willing to do so. Second, assuming that the nursing home cannot meet the medical needs of the recipient, the nursing home would not be "qualified to perform" the services needed and there would consequently be no right of admission.

Appendix I

There is no other provision of the statute or regulations that grants such a right of admission. Therefore, we believe that the nursing home's action would be legal.

Question 2

Can a nursing home deny admission to Medicaid patients who have no responsible party to pay for services not covered by Medicaid, while admitting Medicaid patients that do have such responsible parties?

Response

We believe that the answer is affirmative because section 1902(a)(23) of the Act does not establish a right of admission for the first category of recipients where the provider has not "undertaken to provide (the) services." Once again there is no other Medicaid provision which would prohibit such discrimination.

However, States may legislate in the area of nursing homes' ability to deny access to Medicaid recipients. If by State law a nursing home is prohibited from denying access in general or in the particular situations discussed here, then the action would be illegal under State law and therefore the provider would not be "qualified" to participate in the Medicaid program because State provider requirements are not met. For example, the State could require the nursing home in (1) to obtain the needed services, or in (2), prohibit discrimination against recipients without a responsible party.

After discussing this question with Gerry Furgason of your staff, we found that the issue is whether a nursing home can charge or solicit money from a patient or patient's relatives as a condition of admission.

While nothing in the Medicaid statute or regulations compels a provider of institutional services to admit a Medicaid recipient, section 1909(d)(1)(A) prohibits the charging of a fee as a precondition to admitting a patient whose care is paid for by Medicaid. Thus, we believe that there may be a potential violation of the statute when a prospective patient who receives Medicaid benefits is eligible to have Medicaid pay for care in the nursing home is required to contract with the facility to pay an amount in excess of the Medicaid rate as a condition of admission. This may be viewed as the charging or soliciting of "money . . . as a precondition of admitting a person" to the facility when the cost of that person's care is to be paid for by Medicaid.

It should be noted that OGC has advised that section 1909(d) is a criminal statute and that no one within this Department can give a definitive interpretation regarding the scope and applicability of a criminal statute since those matters are within the province of the Department of Justice, individual United States attorneys, grand juries, and ultimately the courts. If it appears that a potential section 1909(d) violation is involved, the case should be referred to the OIG. (See our policy information memorandum on this subject dated June 14, 1963).

Question 3

If a State refuses to execute an agreement with a certified facility, would this violate a recipient's rights to free choice of provider?

Response

This issue does not concern limiting the recipient's right to free choice of provider, but rather whether or not the State has "good cause" to refuse to enter into a provider agreement. The question of allowability of a State's refusal to enter into an agreement is therefore not merely one of interpretation of section 1902(a)(23) and 42 CFR 431.51. 42 CFR 442.12(d) specifically states the rules in this area. If a State has adequate documentation showing "good cause," it may refuse to execute an agreement with a certified facility. Regulations at 42 CFR 442.12(d)(1) provide that if the Medicaid agency has adequate documentation showing good cause it may refuse to execute an agreement, or may cancel an agreement, with a certified facility. According to OGC, avoidance of overbedding may be used as a "good cause" for not entering an agreement.

We have the following comments on the questions and answers regarding limits on ICF beds in the Regional Office Manual transmittal (HCFA-ROM-24, June 15, 1979) attached to your memorandum.

Question 1. We believe that the answer is correct, with two additional requirements: the State must not violate the requirements of section 1902(a)(8) that medical assistance be furnished "with reasonable promptness" to all eligible individuals; and the limitation can only be accomplished by refusal to enter into provider agreements or by cancellation of existing agreements. See answer to Question 2 below.

Question 2. The answer is incorrect. A State may not place such a percentage limitation on available beds. 42 CFR 442.12(d), discussed above, gives the States latitude only to refuse to execute provider agreements or to cancel such agreements for good cause. There is no provision granting a State the authority to place a percentage limitation on beds. This position has been challenged by two States (Mississippi and South Carolina) in the form of petitions to HCFA to reconsider its disapproval of State plans containing bed limits. Neither petition reached final decision because each was withdrawn by the State prior to that time. It therefore remains HCFA's position that a percentage bed limitation is not allowable.

If you have any questions concerning our response, contact Michele Bowser, FTS-987-0564 on the first three issues and Walt Rutemueller at FTS-934-8831 on the comments on the questions and answers regarding limits on ICF beds.

Larry A. Oday

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

FQA-63

Memorandum

Date JUN 14 1983

From Director
Bureau of Eligibility, Reimbursement, and Coverage

Subject Medicaid Admissions to New Jersey Nursing Homes--(Your Memorandum Dated May 24, 1983)--POLICY INFORMATION FOR ALL REGIONS

To Regional Administrator
Region II, New York
Attn: Policy and Technical Assistance Branch
Division of Program Operations

In your memorandum you brought up the problem that some New Jersey nursing homes have been refusing to accept Medicaid or potential Medicaid eligible patients unless the patient or their families pay at the private pay level for a specific time period under contracts between the nursing home and the patients or their families.

As we pointed out in our interim memorandum of July 22, 1982, there is no Federal prohibition against private individuals who are not Medicaid recipients entering into such contracts with nursing homes. We also indicated we would consult with our Office of the General Counsel regarding the application of section 1909(d) of the Social Security Act to these contracts. The Office of the General Counsel has advised us that section 1909(d) is a criminal statute and that no one within the Department can give a definitive interpretation regarding the scope and applicability of a criminal statute since those matters are within the province of the Department of Justice, individual United States Attorneys, grand juries, and ultimately the courts. Where information is available suggesting a potential violation of section 1909(d), such cases should be referred to the Office of the Inspector General for investigation and appropriate action. (e.g., referral to the appropriate United States Attorney's Office). The advice below is thus provided on an informal basis.

1. If a patient, who has signed singly such an agreement with a nursing home, becomes Medicaid eligible prior to the expiration date of the agreement, can the contract be voided legally and the costs of his stay in the facility then be reimbursed by the State Medicaid agency?

Section 1909(d)(1)(B) prohibits the charging or soliciting of "money--or other consideration--as a requirement for the patient's continued stay in (the) facility." Therefore, in the case of a private pay patient who becomes Medicaid eligible, and Medicaid assumes the cost of care in the facility, a contractual provision requiring the continued payment of private pay rates seems contrary to section 1909(d)(2)(B). Although the statute may not have applied to the agreement when it was executed (because the patient was not a Medicaid beneficiary), payments under the agreement in excess of the Medicaid rate cannot be charged once the individual's care is covered by Medicaid.

Appendix J

3. If a contract is signed jointly by patient and relative and the patient is determined to be Medicaid eligible prior to its expiration can that contract be voided as well and reimbursement be picked up by Medicaid?

The prohibition in section 1909(d)(1)(B) applies not only to the charging or soliciting of money from the patient but from anyone, including relatives of the patient. Therefore the continued payment of private pay rates seems contrary to section 1909(d)(1)(B) for the reasons noted in response to question 1.

3. Can a contract between the patient's relative and the facility be declared invalid if, prior to its termination, the patient is determined to be eligible, and ecn reimbursement then be picked up by Medicaid?

The answer given for question number 2 would apply.

4. Some facilities require "private pay" contracts to be signed by prospective patients who are already Medicaid eligible prior to admission. Are such contracts valid?

Section 1909(d)(1)(A) prohibits the charging or soliciting of "money . . . or other consideration . . . as a precondition of admitting a patient to a skilled nursing facility, or intermediate care facility,". Therefore the requiring of such a contract seems contrary to the statute.

If you have any questions please contact Dick Born FTS-8-634-6443.

Larry A. Oday

Appendix 5

LETTER AND ENCLOSURES FROM LAWRENCE R. PAYNE, DIRECTOR, MEDICAL ASSISTANCE COMPLIANCE ADMINISTRATION, DEPARTMENT OF HEALTH AND MENTAL HYGIENE, STATE OF MARYLAND, TO DAVID SCHULKE, INVESTIGATOR, U.S. SENATE SPECIAL COMMITTEE ON AGING, DATED SEPTEMBER 28, 1984

DEAR MR. SCHULKE: This letter is to convey information requested regarding the use, by nursing facilities participating in Maryland's Medical Assistance Program (Program), of Admission Agreements requiring specified periods of private payment prior to acceptance of medical assistance payment and the program's efforts to eliminate the practice.

As you may be aware, in response to my inquiry as to the legality of practice, Maryland's Attorney General, Steven Sachs, issued an Advice of Counsel letter on July 7, 1982 (copy attached). In part, this letter stated that the common practice of requiring private payment for a specified period was not legal. Upon receipt, the Department of Health and Mental Hygiene (Department) issued Attachment 2, the Nursing Home Advisory Notice (Notice) dated July 9, 1982 with the Advice of Counsel letter attached. The Notice directed all facilities participating in Maryland's Program to stop the use of contract provisions requiring specified periods of private payment and amend existing contracts accordingly.

Upon publication in the newspapers of the Attorney General's position and the actions of the Department of Health and Mental Hygiene, state offices began receiving telephone calls and letters from representatives of patients in nursing homes who had entered such agreements or from those attempting to access nursing facilities and being confronted by such agreements. Initially, the individual complaints were investigated and pursued via telephone and correspondence involving the complainants and the nursing facilities. These investigations were on an individual basis. However, it was made clear to the facilities that the issues had general applicability.

Subsequent to the expiration of the ninety day period provided by the Notice for facilities to amend existing Admission Agreements, a coordinated effort of the Licensing and Certification Division and the Program, with support from the Attorney General's Office, was initiated to investigate facilities allegedly out of compliance with the provisions of the Notice. In all, eleven on-site investigations were conducted. Under the authority of the Department, all business records of patients in facilities selected for on-site investigation were reviewed. Portable photocopy machines were employed to gather evidence.

If a facility was found out of compliance, the Program imposed fiscal sanctions in accordance with state Program regulations (Attachment 3). In accordance with the regulations, the facility was allowed thirty days to submit evidence of compliance, or to appeal the imposition of sanctions. Either action resulted in the continuation of Program payment.

As a result of these investigations, all eleven facilities were found to be out of compliance and sanctions were imposed via certified letter (see Attachment 4 for sample). Some facilities immediately took action to comply with the specifications of the Notice; others filed appeals.

Elements of the nursing facility industry joined to file suit against the Department on this issue. The Department and the representatives of the industry agreed to bypass the state appeal system and go directly to federal court; however, the federal judge remanded the issue to the state appeal system.

The Hearing Officer's recommended decision was in favor of the Department's position (Attachment 5); however, in Maryland the Hearing Officer's decision is not final until signed by the Secretary of the Department. The appellants exercised their right to an Exceptions Hearing prior to the Secretary's acceptance of the

Hearing Officer's recommendation. Finally, the Secretary issued a final decision (Attachment 6). As of the time of this writing, that decision has been appealed to the state's Board of Review and a hearing date has been set.

There has yet to be a negative impact on the Medical Assistance Program resulting from Departmental actions on this issue. No facilities have withdrawn from the Program. In fact, more nursing facilities and, thus more nursing facility beds are available to Medical Assistance recipients today than before (Attachment 7).

The Department consolidated the first three Appeals into one Hearing. Even as the Hearing was being held, more Appeals were filed by nursing facilities found via on-site investigation to be out of compliance with the Notice. As a decision had not been rendered on the first Appeals heard, the appellants had united to fight the Department's position and were using, in most cases, the same law firm. As the issue in each Appeal was the same, the Department and the appellants agreed to consolidate all Appeals on this issue into the Hearing which had already been heard. Ultimately, twenty-four nursing facilities became parties to the Appeal.

Throughout this process, the majority of the facilities who have appealed the Department's action have continued to require private payment from Medicaid eligible patients for contractually specified periods of time. Should the Department ultimately prevail, the issue of retroactive benefits under Medical Assistance for eligible patients in these facilities will need to be addressed.

Additionally, it has come to the attention of the Department that some facilities that no longer contractually require private payment have implemented a more thorough review of an applicant's financial resources. The objective of this financial review is to screen applicants in such a fashion as to identify those who will be able to pay privately for predetermined periods of time. Commonly, the desired period of private payment is one year. Applicants are then selected from the waiting list, in part, on their ability to pay, thus again discriminating against Medicaid patients. Therefore, under this scenario the Department has successfully eliminated contractual requirements for private payment, but has not made nursing facilities more accessable to Medicaid eligible recipients. There are at least two possibile solutions to this problem. One, require nursing facilities to establish waiting lists of applicants and accept applicants on a first come first serve basis. Two, as Minnesota had done, prohibit nursing facilities participating in the Program from charging private patients more than the Medical Assistance payment rate. Both solutions have merit and problems.

It is significant that, currently, the imposition of private paying contracts impacts patients accessing nursing facilities as skilled Medicare patients most severely (see Attachment 1). In July 1982, 31% of all Maryland nursing facility beds had a requirement of private payment. Of the beds certified for the Medicare and Medicaid Programs (triple certified), 25% required private pay contracts. Currently, as a result of Departmental action, only 14% of nursing facility beds require private payment; however, 22% of the beds participating in Medicare and medicaid still require private pay contract. The period of private payment is required subsequent to the exhaustion of Medicare benefits. Thus, facilities which admit a patient as Medicare skilled require the private payment for a contractually specified time before accepting Program payment. Facilities which financially screen applicants to ensure their ability to pay privately thus discriminate against patients who are eligible for Medicaid once Medicare benefits are exhausted. In this manner, the use of private payment contracts affects Medicare as well as Medicaid admissions.

I hope this letter and the attached material is responsive to your request. Should you have any questions, please don't hesitate to call me at (301) 383-6367.

Sincerely,

LAWRENCE R. PAYNE, *Director.*

Attachments.

Attachment 1

Chronology of Events

Advise of Council Letter	July 7, 1982
Nursing Home Advisory Notice	July 9, 1982
On-site Investigation Initiated	August, 1982
Sanction Letter (1st three facilities)	August, September, 1982
Appeals Filed	October, November, 1982
Federal Court Filing	October 19, 1982
Federal Court Dismissal	January 28, 1983
First Appeal Hearing	March 11, 1983
Appeal Cases Consolidated	August 24, 1983
Hearing Officer's Recommendation of Findings	June 1, 1983
Exceptions Hearing	September 14, 1983
Decision Signed by Department's Secretary	May 8, 1984
Board of Review Appeal Filed	May 25, 1984
Board of Review Hearing Date	October 4, 1984

STEPHEN H. SACHS
ATTORNEY GENERAL

ELEANOR M. CAREY
PAUL F. STRAIN
DEPUTY ATTORNEYS GENERAL

OFFICES OF

THE ATTORNEY GENERAL

Attachment 2

PRINCIPAL COUNSEL
RANDALL M. LUTZ
ASSISTANT ATTORNEY GENERAL

DEPUTY COUNSEL
JACK C. TRANTER
ASSISTANT ATTORNEY GENERAL

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
201 WEST PRESTON STREET
BALTIMORE, MARYLAND 21201
AREA CODE 301-383- 2325

July 7, 1982

Lawrence R. Payne, Director
Medical Assistance Compliance Administration
Office of Medical Care Programs
201 W. Preston Street
Baltimore, Maryland 21201

Dear Mr. Payne:

You have requested our advice regarding the legality of several practices alleged to be engaged in by certain nursing home operators. You have also requested our advice regarding possible courses of action for the Medical Assistance Program ("Program") in addressing these practices. Specifically, the practices you have questioned are the following:

1. Requiring individuals and/or their families to sign a contract agreeing to remain as private pay patients for at least one year before seeking medical assistance eligibility;

2. Requiring individuals and/or their families to supplement medical assistance reimbursement as a condition for admission or continued residence in the home;

3. Encouraging individuals and/or their families to make contributions to nursing homes as a precondition of admission; and,

4. Threatening to discharge Medicaid recipients on grounds unrelated to medical necessity or nonpayment.

Each of these issues will be addressed in turn.

Background of the Problem:

You have indicated that there are currently 194 licensed nursing homes in the State of Maryland. This corresponds to 22,172 licensed beds.

Of these 194 facilities, 184 actually participate in either

39-718 O - 84 - 10

the Medicare or Medicaid programs or in both. The total number of beds available to serve this population is 20,770.

The Medicaid patient census during the month of March, 1982 was 13,428. This means that Medicaid recipients occupied more than 64% of the available beds, or nearly 61% of the total licensed beds in the State.

Despite the substantial Medicaid nursing home population, Medicaid recipients often experience difficulties in obtaining access to available beds. Many recipients spend long months on waiting lists for nursing homes in their area or must accept admission to nursing homes far away from friends and relatives. Many homes prefer to admit private pay patients over Medicaid recipients because of the higher amounts that can be charged to these patients.

As indicated more fully herein, the fourth practice described above will have only a limited impact on Medicaid patients in nursing homes. However, the first three practices will adversely affect many Medicaid recipients.

For example, many nursing homes apparently require potential patients to agree to pay private pay rates for one year. Potential or current Medicaid recipients without outside incomes or sufficient resources or without relatives with sufficient income and resources may be unable to pay these private pay rates for even one month. Thus, these impoverished individuals will frequently be unable to secure admission to an appropriate facility despite the existence of a medical condition requiring institutional treatment. By contrast, wealthier individuals can effectively buy admission to a nursing home through this practice.

As explained in the following discussion, these four practices and their resulting discriminatory effects violate federal and/or state law. The Medical Assistance Program can and should take effective action to remedy these abuses.

Discussion:

1. Nursing home operators may not require individuals and/or their families to sign contracts agreeing to pay private pay rates for a specified period before converting to medical assistance.

Section 1909(d)(2)(A) of the Social Security Act, 42 U.S.C. 1396h(d)(2)(A), provides that:

> Whoever knowingly and willfully . . . charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this title, any gift, money, donation, or other

> consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient) . . . as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility . . . shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

According to the instant allegations, certain nursing home operators are requiring prospective Medicaid patients and/or their families to sign an agreement committing them to pay private pay rates for a specified period (usually one year). The execution of this agreement is a precondition of admitting the patient to the facility. The only remaining element of section 1909(d)(2)(A) that must therefore be satisfied in order to establish a violation is whether this agreement constitutes a gift, money, donation, or other consideration.

Private pay rates for nursing facilities are not controlled by either state or federal law. By contrast, medical assistance reimbursement is limited by state and federal statutes and regulations to those reasonable costs recognized by law. As a result, private pay rates generally exceed the rates paid under the Medicaid program.

By requiring prospective medical assistance recipients to be private pay for a specified period, the nursing home is able to receive the higher, private pay rate for that period. The effect is to increase the level of reimbursement available to the home, a frequently substantial financial benefit. The nursing home operator is therefore receiving a benefit (additional reimbursement) while the patient incurs a detriment (agreeing to pay private rates). The element of consideration is therefore present and a violation of section 1909(d)(2)(A) is established.1/

1/ This advice of counsel letter does not address all of the possible circumstances that may arise with regard to pre-admission contracts. For example, some patients will never become Medicaid-eligible during their stay. Nothing in the Medicaid statute prohibits a nursing home from requiring such an individual to agree to pay a certain dollar amount for a specified period of time. Moreover, in the case of a private pay patient who converts to Medicaid during the initial twelve months, the contract is not necessarily void ab initio. The contract would be unenforceable for any period of time after the person becomes Medicaid-eligible.

The Regional Attorney of the United States Department of Health and Human Services has confirmed that this conduct violates section 1909 of the Social Security Act. This position was first stated to the Office of the Attorney General in 1980 and was reiterated in 1982. (Copies of these federal position statements have been attached for your consideration.) Since that time this Office has been reviewing this problem to determine available remedies.

Apparently some question has been raised regarding the extent to which Article 43, section 565C(a)(18)(v) of the Annotated Code of Maryland may authorize the conduct complained of herein. Section 565C(a)(18)(v) provides that, "An admission contract of a Medicaid certified facility may not require a patient to remain a private pay patient for more than 12 months as a condition for remaining in the nursing home in the event the patient becomes Medicaid eligible." Section 565C(a)(18)(v) therefore arguably authorizes, but does not require, nursing homes to utilize private pay contracts of less than 12 months in duration.

Under the Supremacy Clause of the United States Constitution, any state statute that is inconsistent with a validly enacted federal law is void. Article VI, clause 2 of the United States Constitution provides that,

> This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

See Carleson v. Remillard, 406 U.S. 598 (1972); Townsend v. Swank, 404 U.S. 282 (1971); Graham v. Richardson, 403 U.S. 365 (1971). This requirement is paralleled in Article 2 of the Declaration of Rights of the Constitution of Maryland. Thus, state law cannot authorize conduct prohibited by federal law. The provision of state law implicitly authorizing private pay contracts therefore cannot be given legal effect with regard to a nursing home participating in the Medicaid Program.2/

2/ The conclusion that this provision cannot be given legal effect with regard to nursing homes that participate in the Medicaid Program was recently emphasized in our bill review letter to Senate Bill 951 (1982). That legislation made the rights established under Article 43, section 565C(a)(18) applicable to patients in intermediate care facilities for the mentally retarded. With regard to the instant provision, our bill review letter explained that, "[I]t appears that the Legislature intended to authorize private pay contracts of up to (continued)

2. Nursing home operators may not require individuals and/or their families to supplement medical assistance reimbursement as a condition of admission or continued residence in the home.

42 C.F.R. 447.15 provides that, "A State plan must provide that the medicaid agency must limit participation in the medicaid program to providers who accept, as payment in full, the amounts paid by the agency." This provision is paralleled in the state regulations for nursing homes at COMAR 10.09.10.03I and 10.09.11.03E.

This prohibition on patient supplementation is further emphasized by the criminal sanctions established by section 1909(d)(1) of the Social Security Act, 42 U.S.C. 1396h(d)(1). This section provides that, "Whoever knowingly and willfully . . . charges, for any service provided to a patient under a State plan approved under this title, money or other consideration at a rate in excess of the rates established by the State . . . shall be guilty of a felony. . . ." This provision reaches supplementation sought from a patient, the patient's relative, or from any other person for a service covered under the medical assistance program.

There have already been prosecutions for conduct of the type alleged herein. In United States v. Zacher, 586 F.2d 912 (2d Cir. 1978), for example, the part-owner and administrator of a nursing home had been requiring patient families to pay the difference between the private pay rate and the Medicaid rate directly to the facility. Since this prosecution was brought prior to the enactment of section 1909(d), the conviction had to be reversed. However, the Court noted the enactment of the 1977 amendments to the Social Security Act and indicated that, "Our decision as to the criminality of Zacher's receipt of these payments under the old version of [section 1909(d)], while of great importance to Zacher, should have no impact on the liability of nursing home operators now receiving or soliciting similar payments." United States v. Zacher, supra, 586 F.2d at 913-914, n.3.

3. Nursing home operators may encourage voluntary contributions, but may not require contributions as a precondition of admission or continued residence in the home from patients or from persons related to patients.

Section 1909(d)(2)(A) of the Social Security Act, 42 U.S.C. 1396h(d)(2)(A), set forth in part one, establishes several specific conditions relating to the ability of providers to

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one year. To that extent, the provisions [sic] is inconsistent with federal law and cannot be given effect." (A copy of that bill review letter is attached for your consideration.)

accept contributions. Pursuant to section 1909(d)(2)(B), 42 U.S.C. 1396h(d)(2)(B), these conditions are equally applicable to contributions sought as a requirement for a patient's continued stay in a facility when the cost of the services provided therein are paid for in whole or in part under the State plan.

First, contributions may not be charged, solicited, accepted, or received from patients or from persons related to patients when those contributions are sought as a precondition of admitting the patient to a facility or as a requirement for the patient's continued stay. Any such contributions must therefore be truly voluntary.

Second, charitable, religious, or philanthropic contributions may be charged, solicited, accepted, or received from organizations or from persons unrelated to patients even if those contributions are being sought as a precondition of admitting a patient to a facility or as a requirement for the patient's continued stay. However, under Maryland law, even if the contribution is not made, the facility cannot transfer or involuntarily discharge a current patient unless one of the other conditions in Article 43, section 565C(a)(18)(i) is met.

Third, contributions may be sought from any party for services that are not paid for in whole or in part by the Medicaid program. The longstanding regulatory requirement, that Medicaid reimbursement must be accepted as reimbursement in full, is only triggered when there is at least some Medicaid reimbursement for a service. See, 42 C.F.R. 447.15. See also, 42 U.S.C. 1396h(d)(1). Thus, contributions can be sought for such personal comfort items as televisions which are not covered in whole or in part under the Medicaid program.

4. Nursing home operators participating in the Medicare and/or Medicaid programs may not discharge residents on grounds that are not enumerated in 42 C.F.R. 405.1121(k)(4) and 442.311.

Federal regulations establish conditions of participation for nursing homes in the Medicare and Medicaid programs. One of these conditions requires nursing homes to establish written policies and procedures that insure that each resident will "be transferred or discharged only for - (1) Medical reasons; (2) His welfare or that of the other residents; or (3) Nonpayment except as prohibited by the Medicaid program." 42 C.F.R. 442.311(c); see also, 42 C.F.R. 405.1121(k)(4). Nursing homes that violate these conditions may not participate in the Medicare or Medicaid programs. 42 C.F.R. 405.1121, 442.230. Thus, no resident may be discharged from a nursing home participating in the Medicare or Medicaid programs except for one of the three authorized reasons.

Article 43, section 565C of the Annotated Code of Maryland establishes similar safeguards for nursing home residents in the State of Maryland. However, whereas the federal regulations protect only those residents living in nursing homes

participating in the Medicare and/or Medicaid programs, section 565C protects all patients regardless of the status of the home.

Section 565C authorizes involuntary transfers or discharges for the three conditions permitted by federal law. In addition, section 565C authorizes involuntary transfer or discharge of a patient who violates "contract provisions by knowingly divesting himself of his personal assets for the sole purpose of receiving medical assistance." Ann. Code of Maryland, art. 43, §563C(a)(18)(i)(3). Since the federal regulations only reach nursing homes participating in the Medicare and/or Medicaid programs, the only question of possible inconsistency arises with regard to an attempted involuntary transfer or discharge of a resident in a Medicare and/or Medicaid certified home whose transfer or discharge is being sought solely on the basis that he knowingly divested himself of assets.

As discussed in part one, a review of the Maryland provision must necessarily start with a recognition that any state statute that is inconsistent with federal law is invalid under the Supremacy Clause. Thus, no patient in a Medicare and/or Medicaid certified home may be discharged except for one of the three reasons enumerated under the federal regulation. However, an examination of the state statute reveals that any inconsistency would be unlikely to arise.

Section 565C(a)(18)(i)(3) was added to Article 43 after the decision of the Court of Appeals for the Fourth Circuit in Fabula v. Buck, 598 F.2d 869 (4th Cir. 1979). That decision enjoined enforcement of the Maryland regulation that disqualified from medical assistance those persons who knowingly divested themselves of personal assets for the sole purpose of receiving medical assistance. A legislative amendment was therefore sought by the nursing home industry and enacted by the legislature in the third reading of H.B. 137 (1980) in order to discourage a significant number of private pay patients from transferring assets for the sole purpose of qualifying for medical assistance. This change assured that nursing homes could continue to receive the higher private pay rates for these patients for at least 12 months. Ann. Code of Maryland, art. 43, §565C(a)(18)(v).

In 1981, the United States Congress enacted an amendment to the Social Security Act that authorized states, for the first time, to penalize certain recipients who transferred assets in order to qualify for Medicaid. Pub.L. 96-611, sec. 5(b). These provisions are now contained in section 1902(j) of the Social Security Act, 42 U.S.C. 1396a(j).

Pursuant to this federal authorization, the Department of Health and Mental Hygiene adopted a regulation, effective November 1, 1981, that disqualified from medical assistance certain individuals who transferred assets in order to qualify

for Medicaid COMAR 10.09.01.10D. Thus, any recipient who unlawfully transfers assets in order to qualify for Medicaid will be disqualified from the Program for up to two years. Such an individual will also be ineligible for Medicaid reimbursement of nursing home care and could then be transferred or discharged for nonpayment if no reimbursement is made to the home.

It is theoretically possible for some recipients to transfer assets, suffer a disqualification period, and then become eligible for Medical Assistance. The instant contract provisions could thereby come into play. However, federal law would prohibit a nursing home from transferring or discharging a patient under such circumstances despite the seeming authorization under state law.3/

5. Remedies

Three types of remedies are available to address the conduct complained of. First, criminal sanctions can be sought against providers who violate applicable criminal provisions. Second, civil administrative sanctions can be sought against providers who violate applicable rules of conduct. Third, civil judicial proceedings can be initiated against providers who engage in conduct that is prohibited by state or federal law.

a. Criminal Sanctions

In appropriate situations, criminal prosecutions can be initiated by either the Medicaid Fraud Control Unit, for conduct that violates state criminal laws, or by the United States Attorney, for conduct that violates federal criminal statutes. We note that the discretionary decision to prosecute would not likely be exercised where nursing homes engaged in a prohibited practice in a good faith misunderstanding as to applicable law, particularly where state law appeared to authorize the practice. However, these prosecution units may well be interested in pursuing cases of a more flagrant nature, particularly where the nursing home refused to conform its conduct to applicable law after receiving notification of the illegality of the conduct. We suggest below that such notification take place as soon as it is feasible to do so.

We recommend that you continue your practice of referring

3/ Senate Bill 951 also applied this provision to patients in intermediate care facilities for the mentally retarded. The bill review letter emphasized that, "Senate Bill 951 . . . cannot withdraw rights that are guaranteed by federal law. To the extent that it authorizes conduct that is proscribed by federal law, it cannot be given effect."

suitable cases to the appropriate prosecution units and that you confer with those units about whether referrals for prosecution in any particular class of cases is warranted.

b. Administrative Sanctions

The Department is required to monitor current policies and practices of providers and may invoke appropriate sanctions under state law. These sanctions are set forth in COMAR 10.09.10.16A. and 10.09.11.16A. as follows:

> If the Department determines that a provider, any agent or employee of the provider, or any person with an ownership interest in the provider has failed to comply with applicable federal and State laws and regulations, the Department may initiate one or more of the following actions against the responsible party:
>
> (1) Suspension from the Program;
>
> (2) Withholding of payment by the Program;
>
> (3) Removal from the Program;
>
> (4) Disqualification from future participation in the Program, either as a provider or as a person providing services for which Program payment will be claimed.

The Program therefore has various options as to possible sanctions against homes that continue to violate federal law.

In deciding whether or not to initiate administrative proceedings against a particular home, the Medical Assistance Compliance Administration may wish to consider the extent to which confusion regarding state law contributed to violations of section 1909(d) of the Social Security Act. Unlike the interface with criminal law, the regulations vest considerable discretion in your office to determine whether initiation of sanctions is appropriate.

The imposition of administrative sanctions to remedy past practices raises a difficult question. This office is not aware of any cases in this State in which sanctions, such as withholding of current reimbursement, have been imposed to make patients and their families whole. If you determine that an appropriate case exists for such an approach, we should review the various legal options available to the Program.

It appears that the conduct complained of may be widespread in the industry. In order to encourage maximum compliance with

the applicable requirements of law, your office may wish to consider sending a warning notice as a first step to all providers advising them of the illegality of the various practices. For those providers engaging in these practices in ignorance of federal law, this education effort may thereby discourage future violations.

The Office on Aging should also be advised of these possible violations of federal law in order to expedite notification to current patients and their families. This information might also be included in future recipient mailings from the Program.

The Medical Assistance Compliance Administration will also need to investigate complaints by recipients and families. Determining the factual basis for complaints may often be a difficult task. For example, with regard to encouragement of patient or relative "contributions" as a precondition of admission, your investigations may reveal that patients and/or their relatives are being led to believe that a contribution will facilitate or guarantee their admission.

In such cases, it may be necessary to go behind the express language contained on forms provided by a facility. While the literature provided by a facility may indicate that contributions are voluntary, in practice only those individuals who make contributions may be accepted from the waiting list. The Program will therefore need to review the admissions practices of facilities in addition to conducting interviews with patients and their families.

c. Civil Proceedings

In light of the availability of administrative sanctions, the Medical Assistance Program will generally not be involved in initiating civil proceedings against providers. However, patients and/or their relatives may seek to set aside existing contracts or to recover monies paid pursuant to unlawful private pay contracts. In such cases, the Medical Assistance Program may wish to intervene on the side of patients and their families as an amicus curiae, friend of the court, to discuss the relationship of federal and state law. The Office of the Attorney General is willing to participate in an appropriate capacity on behalf of the Program in any challenges to such contracts.

Conclusion:

We hope that this discussion adequately addresses the legal consequences of the conduct described in your request. Please

feel free to contact this office if you would like to discuss these issues further.

Very truly yours,

Stephen H. Sachs
Attorney General

David F. Chavkin
Assistant Attorney General

SHS/DFC:kaa

STEPHEN H. SACHS
ATTORNEY GENERAL
ELEANOR M. CAREY
DEPUTY ATTORNEY GENERAL
PAUL F. STRAIN
DEPUTY ATTORNEY GENERAL

OFFICES OF

ROBERT A. ZARNOC
ASSISTANT ATTORNEY GE
COUNSEL TO THE GENERAL AS
RICHARD E. ISRAE
ASSISTANT ATTORNEY GE
LINDA H. LAMONT
ASSISTANT ATTORNEY GE

THE ATTORNEY GENERAL

104 LEGISLATIVE SERVICES BUILDING
90 STATE CIRCLE
ANNAPOLIS, MARYLAND 21401-1991
AREA CODE 301
BALTIMORE & LOCAL CALLING AREA 841-3888
WASHINGTON METROPOLITAN AREA 858-3888
TTY FOR DEAF — ANNAPOLIS 841-3814 — D.C. METRO 858-3814

May 24, 1982

The Honorable Harry Hughes
Governor of Maryland
State House
Annapolis, Maryland 21404

Re: Senate Bill 951

Dear Governor Hughes:

This office has reviewed for constitutionality and legal sufficiency Senate Bill 951. This bill would define certain limited circumstances under which patients in intermediate care facilities for the mentally retarded could be involuntarily transferred or discharged. Although the bill may be signed into law, two provisions of the legislation conflict with federal law and, because of the Supremacy Clause of the U. S. Constitution, must be applied in accordance with federal law.

The first provision is found in the amendment enacting Section 7-709(B)(3). This provision authorizes intermediate care facilities for the mentally retarded (ICF/MR) to involuntarily transfer or discharge a patient who knowingly transfers personal assets in violation of contract provisions and only to become eligible for medicaid benefits.1/

1/ This provision was modeled after a provision in the Health-General Article, §19-345 (former Article 43, §565C(a)(18)(i) 3.) that defines the rights of patients in skilled nursing facilities and intermediate care facilities. This provision raised similar problems under federal law and was the subject of a previous bill review letter regarding House Bill 137 (1980). That provision was enacted in the wake of a United States District Court decision invalidating the Maryland prohibition on transfers of assets. Since that time, federal law has been changed to authorize such prohibitions and a new State regulation was promulgated last year.

All patients in skilled nursing facilities, intermediate care facilities, and intermediate care facilities for the mentally retarded have certain rights under federal law. These rights are known generically as the Patients' Bill of Rights. 42 C.F.R. 442.404(c) defines the circumstances under federal law when patients can be involuntarily transferred or discharged. The only circumstances permitted under this section are transfers or discharges for medical reasons, for the welfare of the patient or the welfare of other residents, or for nonpayment. Violation of contract provisions on transfers of assets are not a permissible basis for transfer or discharge.

We are left then with a bill provision that expressly authorizes conduct that is prohibited under federal law. There is a slight difference in the scope of the State bill and the federal regulations. The federal regulations protect all patients in all facilities that receive either Medicare or Medicaid reimbursement. The State bill would apply to all patients in all facilities. As a practical matter, however, the scope of the two provisions would be coextensive.

Pursuant to Article VI, Clause 2 of the United States Constitution and Article 2 of the Maryland Constitution, this federal law must control as the supreme law of the land. The instant provision of Senate Bill 951 therefore cannot withdraw rights that are guaranteed by federal law. To the extent that it authorizes conduct that is proscribed by federal law, it cannot be given effect.

The second problem in the bill concerns the language contained in Section 7-709(D)(1)(I). This provision prohibits contractual provisions that require patients to remain as private pay patients for longer than one year. Conversely, it implicitly authorizes similar contractual provisions requiring patients to remain as private pay patients for up to one year.

Section 1909(d) of the Social Security Act prohibits facilities participating in the Medicaid program from requiring such pre-admission contracts. This office has been advised on two occasions of the illegality of this conduct (see attached letters) and has advised the Department of Health and Mental Hygiene of this analysis. Moreover, in the near future, this office will be advising all nursing homes operating in the State of Maryland of the criminal penalties applicable to those persons who require patients and/or their families to sign such contracts.

Senate Bill 951 would not mandate facilities to require such private pay contracts. We therefore do not have a direct

violation of federal law. However, it appears that the Legislature intended to authorize private pay contracts of up to one year. To that extent, the provisions is inconsistent with federal law and cannot be given effect.

In conclusion, it appears that this bill was intended to limit presently permitted practices and thereby protect patients from certain abusive conduct. To the extent the bill does so, not inconsistent with federal law, these provisions may be given effect if the bill is signed into law. However, those provisions discussed above which limit the rights of patients conflict with federal law and may not be given effect.

Very truly yours,

Stephen H. Sachs
Attorney General

SHS/DFC:ipb

cc: Carl Eastwick, Esq.
F. Carvel Payne
Hon. Fred L. Wineland
Hon. Melvin Steinberg

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the
Regional Attorney

May 11, 1982

Region III
P.O. Box 13716, 3535 Market St.
Philadelphia, PA 19101

David F. Chavkin
Assistant Attorney General
Office of the Attorney General
Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, MD 21201

Dear Mr. Chavkin:

At your request, we have reviewed your draft memorandum to the Maryland Office of Medical Care Programs concerning the legality of the practice whereby certain Maryland nursing home operators require individuals and/or their families to sign contracts agreeing to pay private pay rates for a specified period before converting to Medicaid as a source of payment. We concur with your conclusion that, regardless of the State law provisions at Article 43, section 565C of the Annotated Code of Maryland, this conduct violates federal criminal provisions at §1909 of the Social Security Act, 42 U.S.C. §1396h(d)(2)(A), when the facility entering into such contracts is a Medicaid provider. Indeed, as you can see by the attached copy of a letter to State Medicaid agency counsel dated May 27, 1980, we are simply reiterating our legal position that such conduct violates federal law.

As you know, the federal program requirements do not mandate that providers accept Medicaid patients. There is general awareness that Medicaid beneficiaries often experience more difficulty than private pay patients in gaining admission to long term care facilities. This issue is well illustrated by a Notice of Proposed Rulemaking published on July 14, 1980 (45 F.R. 47372) concerning "selection of patients by source of payment," which states as follows:

> We solicit comments on what, if any, regulatory involvement is appropriate with regard to facility policies on admitting Medicare or Medicaid patients.
>
> There is an apparent shortage of nursing home beds for Medicare and Medicaid patients. They appear to be on waiting lists longer than private pay patients who rarely seem to have trouble finding an available bed. For Medicare beneficiaries, the problem is a shortage of certified beds; for Medicaid beneficiaries, the problem is gaining admission. We note that participation in Medicare and Medicaid is voluntary, and some facilities may now compensate for low government reimbursement rates by maintaining a certain proportion of private pay patients.

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BEST COPY AVAILABLE

In our view, although a Medicaid provider may opt to enhance its reimbursement by admitting only private pay patients without violating federal law and regulations, a provider may not contract to accept a patient as a Medicaid beneficiary under the condition that the provider first receive payment at the private rate for up to a year. In this situation, we agree with your conclusion that the provider has not merely exercised its concealed right to discriminate among prospective patients based on the source of payment for their care, but has imposed a pre-admission condition directly related to Medicaid eligibility in violation of §1909(d)(2)(A) of the Social Security Act, 42 U.S.C. §1396n(d)(2)(A).

We also concur in your observation that federal legislation enacted subsequent to Maryland's State law provisions at Article 43, section 565C goes far towards remedying the circumstances which largely fostered the enactment of this State law, viz., to prevent individuals from transferring their assets for less than fair consideration in order to obtain Medicaid eligibility. See §1902(j) of the Social Security Act, 42 U.S.C. §1396a(j), enacted by Section 5(b), Pub. L. 96-611.

We hope that you will find these comments useful as you finalize your draft opinion on this matter. Let us know if we can be of further assistance.

Sincerely,

David R. Culp
Acting Regional Attorney

By: Diane C. Moskal
Diane C. Moskal
Assistant Regional Attorney

Attachment

BEST COPY AVAILABLE

May 27, 1980

Re: Federal Prohibition
Against Nursing Home
Preadmission Requirements
for Medicaid Patients

Susan K. Gauvey
Assistant Attorney General
Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, Maryland 21201

Dear Ms. Gauvey:

This is in response to your letter of May 6, 1980, requesting that we advise you of the legal support for the Regional Medicaid Director's letter of January 15, 1980 which informed the State Medicaid agency that ". . . nursing homes cannot require that a medical assistance recipient pay privately in order to gain admittance to the home."

Section 4(b) of Public Law 95-142 (October 25, 1977) amended section 1909 of the Social Security Act (42 U.S.C. §1396h); 42 U.S.C. §1396h(d) provides as follows:

> (d) Whoever knowingly and willfully—
> (2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this subchapter, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)—
> (A) as a precondition of admitting a patient to a hospital skilled nursing facility, or intermediate care facility. . . when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan, shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

The Department has not yet promulgated regulations under this statutory provision, but we believe that the statute itself explicitly and clearly prohibits the situation reportedly identified by the Central Maryland PSRO, i.e., the refusal of some Maryland Medicaid providers to accept Medicaid patients into nursing homes unless the patients are able to pay privately for a period of from 18 months to two years.

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39-718 O - 84 - 11

Page 2 - Susan F. Gauvey, Assistant Attorney General

Please let us know if you have further questions on this matter.

Stephanie W. Haidoff
Regional Attorney

By: _____
James C. Newman, Supervisory
Assistant Regional Attorney

cc: Everett Bryant

Harvey Foster

JCNewman:DC'bshal;mac
MA-80-43

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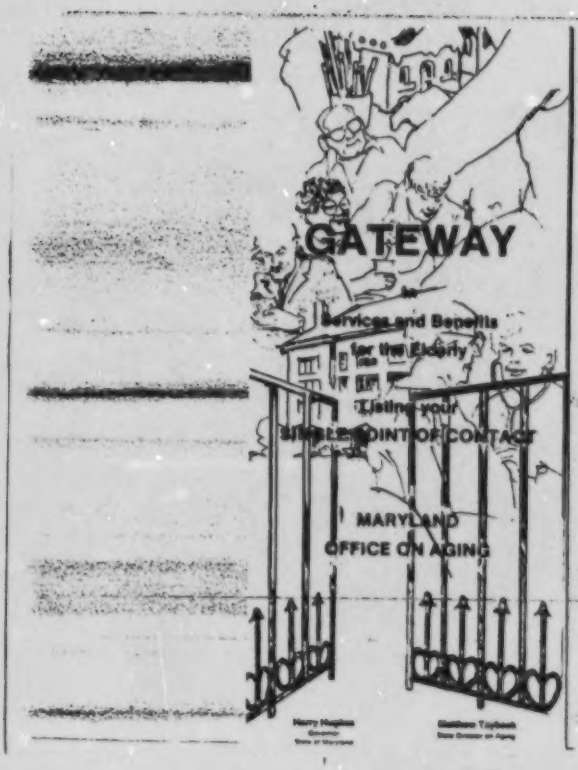

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Scope of Services and Benefits for the Elderly in Maryland

HOUSING:

- Low Cost Housing
- Tax Relief — Homeowners / Renters
- Weatherization / Home Repair
- Fuel Assistance
- Continuing Care

HEALTH:

- Medicare and Medigap Insurance
- Pharmacy Assistance
- Nursing Home Information and Complaints
- Medicaid

COMMUNITY SERVICES

- Senior Citizens Centers
- Daily Meals
- Volunteer Work

INCOME / FINANCIAL AID

- Social Security
- SSI
- Pensions
- Food Stamps
- Unemployment Insurance
- Tax advice and preparation
- Discount Cards
- Veterans Benefits

FOR FRAIL ELDERLY:

- Sheltered Housing
- Day Care and Home Care
- Meals on Wheels
- Nursing Home Care
- Needs Assessment

OTHER:

- Transportation
- Employment
- Legal Services
- Protective Services / Guardianship
- Physical Fitness
- Education

GATEWAY SINGLE POINTS OF CONTACT FOR YOUR CALL OR VISIT

IF YOU LIVE IN:	CALL YOUR GATEWAY TELEPHONE:
ALLEGANY COUNTY	
Cumberland Senior Citizen's Center 19 Frederick Street Cumberland, Maryland 21502	724-1101
ANNE ARUNDEL COUNTY	
Arundel Center North 101 Crain Highway, N.W. Glen Burnie, Maryland 21061	787-8648
BALTIMORE CITY	
Waxter Center for Senior Citizens 861 Park Avenue Baltimore, Maryland 21201	396-1261
BALTIMORE COUNTY	
Baltimore County Department of Aging 611 Central Avenue Towson, Maryland 21204	494-5594 887-3463
CALVERT COUNTY	
Calvert Pines Senior Center 450 West Dares Beach Road Prince Frederick, Maryland 20678	
Southern - local number Central - Metro D.C. number	855-1355 535-1170
CARROLL COUNTY	
Westminster Senior Center Old West End School Building Bellevue Avenue Westminster, Maryland 21157	
from Baltimore from Mt. Airy Woodbine	876-2555 876-9600 842-8640
CHARLES COUNTY	
Charles County Aging Services Office Radio Station Road LaPlata, Maryland 20646	934-3666
FREDERICK COUNTY	
Frederick County Commission on Aging 118 North Market Street Frederick, Maryland 21701	694-1064
GARRETT COUNTY	
Oakland Senior Center 104 East Center Street Oakland, Maryland 21550	334-1239
HARFORD COUNTY	
Harford County Senior Center 145 North Hickory Bel Air, Maryland 21014	
Harford Baltimore	836-6500 879-2900
HOWARD COUNTY	
Howard County Office on Aging Oakland Mills Senior Activity Center Columbia, Maryland 21045	730-7507
MONTGOMERY COUNTY	
Holiday Park Senior Center 3950 Ferrara Drive Wheaton, Maryland 20906	949-5445

IF YOU LIVE IN:	CALL YOUR GATEWAY TELEPHONE:
PRINCE GEORGE'S COUNTY	
Prince George's County Commission of Aging 5012 Rhode Island Avenue Hyattsville, Maryland 20781	699-7155
QUEEN ANNE'S COUNTY	
Queen Anne's County Office on Aging Annex Building Story Lane Centreville, Maryland 21617	758-0546
ST. MARY'S COUNTY	
Carver Senior Center P.O. Box 331 Leonardtown, Maryland 20650	475-5100
WASHINGTON COUNTY	
Senior Citizens Center Alexander House 9 Public Square Hagerstown, Maryland 21740	739-8571
— LOWER SHORE —	
DORCHESTER COUNTY	
Cambridge MAC Multi-Service Senior Citizens Ctr. 420 Muir Street Cambridge, Maryland 21613	228-3567
SOMERSET COUNTY	
Commission on Aging Administrative Office 424 North Somerset Avenue Princess Anne, Maryland 21853	651-0666
WICOMICO COUNTY	
Pine Bluff MAC Multi-Service Senior Citizens Ctr. 1399 Riverside Drive Salisbury, Maryland 21801	548-4994
WORCESTER COUNTY	
Snow Hill MAC Multi-Service Senior Citizens Ctr. P.O. Box 189 107 East Market Street Snow Hill, Maryland 21863	632-1380
— UPPER SHORE —	
CAROLINE COUNTY	
Caroline Senior Center 4th Street Armory Denton, Maryland 21629	479-3656
CECIL COUNTY	
Cecil Senior Center Holly Hall 702 South Bridge Street Elkton, Maryland 21921	398-7320
KENT COUNTY	
County Office Building 400 High Street Chestertown, Maryland 21620	778-6999
TALBOT COUNTY	
Talbot County Health Department 100 South Hanson Street Easton, Maryland 21601	822-0808

After office hours and on holidays, call our Health and Welfare Council of Central Maryland HOTLINE:

Baltimore metropolitan area: 685-0825

Outside the Baltimore metropolitan area: 1-(800)-492-0610 (statewide toll-free)

Attachment 3

Title 10
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 09 MEDICAL CARE PROGRAMS

Chapter 11 Intermediate Care Facility Services

Authority: Article 41, 1306; Health-General Article, 19-106(b) and 15-106; Annotated Code of Maryland

.01 Definitions.

A. The following terms have the meanings indicated.

B. Terms Defined.

(1) "Accrual basis" means recording revenue in the period when earned, regardless of when collected, and recording expenses in the period when incurred, regardless of when paid.

(2) "Activity of Daily Living (ADL)" means one of five functions (bathing, dressing, mobility, continence, eating) for which nursing home residents are to be evaluated in terms of requiring help in the performance of the function.

(3) "ADL classification" means one of four categories into which a resident will be assigned on the basis of the number of Activities of Daily Living in which the resident is found dependent during a patient assessment and the types of procedures the facility is required to provide to the resident.

(4) "Administrative day" means a day of care rendered to a recipient who no longer requires the level of care being provided.

(5) "Allowable cost" means costs that are includable in the per diem rate and that represent the provider's actual cost as verified by the Department or the Department's designee.

(6) "Appropriate facility" means a facility located within a 25-mile radius of the location of the facility currently rendering care to the recipient or a more distant facility if acceptable to the recipient which facility is licensed and certified to render the recipient's required level of care.

(7) "Bad debts" means amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in

C. A provider may not use a recipient's personal needs fund for care or services which are either allowable as part of the per diem cost or otherwise covered by the Medical Assistance Program.

D. Upon request during normal business hours, 7 days a week, for a minimum of 3 hours each day, a provider shall allow a recipient to withdraw or otherwise use his personal needs fund.

E. A provider may not use a recipient's personal needs fund for care or services not requested or not provided. A recipient's personal needs fund may not be used to retire a pre-existing debt.

.17 Recovery and Reimbursement.

A. If the recipient has insurance, or if any other person is obligated either legally or contractually to pay for or to reimburse the recipient for any service covered by this chapter, the provider shall seek payment from that source. If payment is made by both the Program and the insurance or other source, the provider shall refund to the Department, within 60 days of receipt, the amount paid by the Program, or the insurance or other source, whichever is less.

B. The provider shall reimburse the Department for any overpayment.

.18 Cause for Suspension or Removal and Imposition of Sanctions.

A. If the Department determines that a provider, any agent or employee of the provider, or any person with an ownership interest in the provider has failed to comply with applicable federal or State laws or regulations, the Department may initiate one or more of the following actions against the responsible party:

(1) Suspension from the Program;

(2) Withholding of payment by the Program;

(3) Removal from the Program;

(4) Disqualification from future participation in the Program, either as a provider or as a person providing services for which Program payment will be claimed.

B. If the Secretary of Health and Human Services suspends or removes a provider from participation in Medicare, the Department will take similar action.

C. The Department will give reasonable written notice to the intermediate care facility, to recipients, recipients' next of kin, and others who may be affected, of its intention to impose sanctions. The written notice will state the effective date and specific reasons for the proposed action, and advise the provider of the right to appeal.

D. A provider who voluntarily withdraws from the Program or is removed or suspended from the Program according to this regulation shall notify recipients that he no longer honors Medical Assistance cards before he renders additional services.

.19 Appeal Procedures.

Providers filing appeals from administrative decisions made in connection with these regulations shall do so according to Health-General Article, §2-207, and Article 41, §244 et seq., Annotated Code of Maryland.

.20 Interpretive Regulation.

Except when the language of a specific regulation indicates an intent by the Department to provide reimbursement for covered services to Program recipients without regard to the availability of Federal Financial Participation, State regulations shall be interpreted in conformity with applicable federal statutes and regulations.

Administrative History

Effective date: July 9, 1975 (2:15 Md. R. 1074)
Regulation .03 amended effective January 30, 1976 (3:4 Md. R. 216)
Regulation .03H amended effective December 31, 1975 (3:4 Md. R. 216)
Regulation .03S adopted as an emergency provision effective July 1, 1977 (4:15 Md. R. 1144); adopted permanently effective October 21, 1977 (4:22 Md. R. 1671)
Regulation .03Y amended effective September 29, 1976 (3:20 Md. R. 1144)
Regulation .05 amended effective August 17, 1977 (4:17 Md. R. 1300)
Regulation .06 amended as an emergency provision effective April 1, 1977 (4:8 Md. R. 631); emergency status extended at 4:17 Md. R. 1291 (Emergency provisions are temporary and not printed in COMAR)
Regulation .06 amended effective August 17, 1977 (4:17 Md. R. 1300)
Regulation .06B amended effective January 30, 1976 (3:4 Md. R. 216)
Regulation .06C adopted as an emergency provision effective July 1, 1977 (4:15 Md. R. 1144); adopted permanently effective October 21, 1977 (4:22 Md. R. 1671)
Regulation .07 amended effective August 17, 1977 (4:17 Md. R. 1300)
Regulation .09 amended effective August 17, 1977 (4:17 Md. R. 1300)
Regulation .09A amended effective September 29, 1976 (3:20 Md. R. 1144)
Regulation .09B amended as an emergency provision effective April 1, 1977 (4:8 Md. R. 631); emergency status extended at 4:17 Md. R. 1291 (Emergency provisions are temporary and not printed in COMAR)

Regulation .09B, D amended effective January 30, 1976 (3:4 Md. R. 218)
Regulation .09A amended as an emergency provision effective July 1, 1977 (4:15 Md. R. 1144); adopted permanently effective October 21, 1977 (4:22 Md. R. 1671)
Regulation .09A amended as an emergency provision effective June 13, 1978 (5:13 Md. R. 1039); (Emergency provisions are temporary and not printed in COMAR)
Regulations .03 and .09 amended as an emergency provision effective January 1, 1978 (5:1 Md. R. 15); (Emergency provisions are temporary and not printed in COMAR)
Regulations .03, .06, .08, and .09 amended as an emergency provision effective March 15, 1978 (5:17 Md. R. 518); (Emergency provisions are temporary and not printed in COMAR)

Chapter revised effective July 1, 1978 (5:13 Md. R. 1032)
Regulations .01Q, R, W, JJ, MM; .02; .07B amended effective December 14, 1979 (6:25 Md. R. 1950)
Regulation .01M-1 and M-2 adopted effective July 1, 1980 (7:13 Md. R. 1278)
Regulations .01O; .06; .07B amended effective January 1, 1980 (6:26 Md. R. 2074)
Regulations .01P–R and .03K repealed effective January 1, 1980 (6:26 Md. R. 2074)
Regulation .01P adopted effective January 1, 1980 (6:26 Md. R. 2074)
Regulations .01LL, and .08A-1, and .09A adopted effective December 14, 1979 (6:25 Md. R. 1950)
Regulation .07-1 adopted effective July 1, 1980 (7:13 Md. R. 1278)
Regulation .06E amended as an emergency provision effective July 1, 1978 (5:14 Md. R. 1131); adopted permanently effective November 3, 1978 (5:22 Md. R. 1673)
Regulation .11 amended effective December 20, 1982 (9:25 Md. R. 2484)
Regulation .11G adopted as an emergency provision effective October 18, 1979 (6:22 Md. R. 1775); emergency status expired March 1, 1980 (Emergency provisions are temporary and not printed in COMAR)
Regulation .16A, B amended effective August 17, 1981 (8:16 Md. R. 1365)
Regulation .18 adopted effective October 25, 1982 (9:21 Md. R. 2106)

Chapter revised effective January 1, 1983 (9:25 Md. R. 2480)
Regulation .03 amended as an emergency provision effective February 18, 1983 (10:6 Md. R. 536); (Emergency provisions are temporary and not printed in COMAR)
Regulation .13E amended as an emergency provision effective January 1, 1983 (10:1 Md. R. 21); adopted permanently effective May 1, 1983 (10:7 Md. R. 634)

Attachment 4

MEDICAL ASSISTANCE COMPLIANCE ADMINISTRATION
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
300 WEST PRESTON STREET • BALTIMORE, MARYLAND 21201 • Area Code 301 • 383-2795
TTY FOR DEAF: Balto. Area 383-7555 • D.C. Metro 565-0451
Harry Hughes, Governor
Charles R. Buck, Jr., Sc.D. Secretary

December 10, 1982

Mr. Millard L. Cursey, Jr.
Administrator
Holly Hill Manor, Inc.
531 Stevenson Lane
Towson, Maryland 21204

Dear Mr. Cursey:

In a Department of Health and Mental Hygiene Nursing Home Advisory Notice dated July 9, 1982, John L. Green, Acting Secretary, directed all nursing homes licensed by the Department to make certain amendments to their admission contracts and to notify patients and/or their guarantors of those changes. This Notice was pursuant to an Advice of Counsel from the Attorney General which advised that Admission Agreements requiring patients to remain in a private-pay status for a specified period of time before seeking Medical Assistance eligibility are prohibited by Section 1909 (d)(2)(A) of the Social Security Act and, therefore, violation of the Conditions of Participation in the Medical Assistance Program.

In response to the Notice, you notified me by your letter dated October 6, 1982:

> "Upon advice of council Holly Hill Manor Inc. is unwilling to modify its agreements at this time and will continue to use previously State of Maryland approved agreements until the present litigation is resolved."

As a consequence of your stated position, on November 10, 1982 representatives of the Department visited your facility to inspect the contracts you require of individuals admitted, both before and subsequent to the issuance of the Attorney General's Advice of Counsel letter on July 7, 1982. This inspection revealed that of sixty patient records copied:

1. Twenty-eight in residence as of July 7, 1982 and all five admitted subsequent to July 7, 1982 had contracts which

contained the folliwng wording:

> "In accordance with Maryland law the Facility may require the Resident to remain as a private pay resident for no longer than twelve months as a condition for remaining in the Facility in the event the Resident becomes Medicaid eligible."

2. Seventeen in residence as of July 7, 1982 had contracts which contained the following wording:

> "That the Facility will not accept payment for services from any government third party payor programs."

3. Ten in residence as of July 7, 1982 had contracts with amendments which contained the following wording:

> "Holly Hill Manor, Inc. will not accept payment for services from any government third party payor programs."

4. No evidence was found in any record of any contract amendments incorporating the provisions outlined in the Nursing Home Advisory Notice of July 9, 1982.

From the foregoing, it is clear the admission agreements currently in force at Holly Hill Manor violate Federal and State laws and regulations by requiring individuals and/or their families to pay private-pay rates for up to one year prior to acceptance of Medicaid. Further it is clear that Holly Hill Manor, Inc. is in violation of its agreement dated August 25, 1982 with the State Department of Health and Mental Hygiene by refusing to "accept payment from any government third party payor program." Therefore, in accordance with COMAR 10.09.11.16, by copy of this letter I am directing the Medical Assistance Operations Administration to make no further payments for services rendered by Holly Hill Manor, Inc. after January 31, 1983. This sanction will be reconsidered immediately upon presentation of evidence that action has been taken to comply with applicable Federal and State laws and regulations, in accordance with the directions issued in the Department's Nursing Home Advisory Notice of July 9, 1982.

You have the right to appeal this order in accordance with Article 41, Section 206A and 206B and Article 41, Section 244 et seq. of the Annotated Code of Maryland. Filing an appeal stays imposition of the sanctions until the appeal is heard. You may file an appeal by notifying the Department Hearing Examiner within 30 days of receipt of this letter. If you do so, a hearing will then be scheduled at which time you will have the opportunity to contest this decision.

Sincerely,

Lawrence R. Payne

Lawrence R. Payne, Director
Medical Assistance Compliance Administration

LRP:mat

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

301 WEST PRESTON STREET • BALTIMORE, MARYLAND 21201

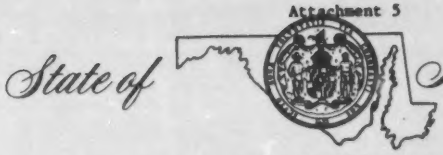
CHARLES R. BUCK, JR., S.C.D.

Mr. William L. Cursey, Jr.
December 10, 1962
Page three

cc: Mr. John L. Green, Deputy Secretary
Ms. Adele Wilzack, Assistant Secretary for Medical Care Programs
Mr. Jerome Miport, Director, Medical Assistance Operations Administration
Mr. Harold Gordon, Chief, Division of Licensing and Certification
Mr. David Chavkin, Assistant Attorney General
Mr. L. Malcolm Rodman, C.A.E., Executive Director, Health Facilities Association of Maryland

bcc: Ms. Jeanne E. Fisher
Ms. Melvina Ford
Mr. Samuel Colgain
Mr. Richard Cederstrom

Attachment 5



OFFICE OF THE SECRETARY
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
300 WEST PRESTON STREET • BALTIMORE, MARYLAND 21201 • Area Code 301 • 383-2642

Harry Hughes, Governor

Charles R. Buck, Jr., Sc.D. Secretary

June 1, 1983

Sanford V. Teplitzky, Esquire
Jervis S. Finney, Esquire
Ober, Grimes &Shriver
1600 Maryland National Bank Building
Baltimore, Maryland 21202

Re: Summit Nursing Home - 82-MAP-264
Frederick Villa Nursing Center - 82-MAP-273
Sykesville Eldercare Center - 82-MAP-274

Gentlemen:

Enclosed please find my proposal for decision, including Statement of Case, Issues, Findings of Fact, Law and Regulations, Conclusion and Recommendation in accordance with Article 41, Section 253, of the Annotated Code of Maryland.

Within fifteen (15) working days after deposit in the mail by this Office of this proposed decision, you may file written exceptions and request to present oral argument to the Secretary or his designee.

Copies of your exceptions must also be mailed to all parties or their counsel at the same time.

A copy of this proposal for decision has also been forwarded to the Secretary on even date.

If no exceptions and request to present argument to the Secretary are filed, the Secretary shall issue his final decision.

Very truly yours,

Steven N. Vogelhut, Esquire
Hearing Examiner
Office of Hearings

SMV/mz
Enc.

SUMMIT NURSING HOME	*	BEFORE A HEARING EXAMINER
FREDERICK VILLA NURSING CENTER	*	OF THE DEPARTMENT OF
and	*	HEALTH AND MENTAL HYGIENE
SYKESVILLE ELDERCARE CENTER	*	
Appellants	*	
vs.	*	HEARING OFFICE DOCKET NOS.
MEDICAL CARE PROGRAMS	*	82-MAP-264
DEPARTMENT OF HEALTH AND	*	82-MAP-273
MENTAL HYGIENE	*	82-MAP-274
Appellee	*	

* * * * * * * * * * * * *

STATEMENT OF CASE,
ISSUES, FINDINGS OF FACT,
LAW & REGULATIONS,
CONCLUSION AND RECOMMENDATION

STATEMENT OF CASE

On July 9, 1982, John L. Green, Deputy Secretary for Operations of the Department of Health and Mental Hygiene for the State of Maryland, issued and distributed to all nursing homes in Maryland certified as Medicaid providers a Nursing Home Advisory Notice. Attached to said Advisory Notice was an advice of counsel letter signed by Stephen H. Sachs, Attorney General for the State of Maryland and two other Assistant Attorneys General.

The part of the Advisory Notice which stated the following was objected to and challenged by the Appellants:

> "1. Nursing home operators may not require individuals and/or their families to sign contracts agreeing to pay private-pay rates for a specified period before converting to Medical Assistance coverage. Federal Law supercedes the Maryland Statute on this subject and Article 43, Section 565C(a)(18)(v) cannot be given legal effect with regard to nursing homes participating in the Medicaid Program."

The statutory authority cited by the Attorney General of Maryland in his advice of counsel letter is Section 1909(d)(2)(A) of the Social Security Act, codified at 42 U.S.C.

§1396h(d)(2)(A). Section 1909(d) designates certain penalties for violations of the Medical Assistance (or Medicaid) statute, and provides as follows:

> "(d) Whoever knowingly and willfully --
>
> (1) charges, for any service provided to a patient under a State plan approved under this subchapter at a rate in excess of the rates established by the State, or
>
> (2) charges, solicits, accepts or receives, in addition to any amount otherwise required to be paid under a State plan approved under this subchapter, any gift, money, donation, or other consideration (other than a charitable, religious, or philantrhopic contribution from an organization or from a person unrelated to the patient) --
>
> (A) as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility,
>
> (B) as a requirement for the patient's continued stay in such a facility,
>
> when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan,
>
> shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both."

42 U.S.C. § 1396h(d).

Article 43, §565C(a)(18)(v) of the Annotated Code of Maryland (recently codified in somewhat modified form in Health General Article § 19-345(c)(1)(i) (1982)), referred to in the Advisory Notice, provides:

> "An admission contract of a Medicaid certified facility may not require a patient to remain a private-pay patient for more than twelve months as a condition for remaining in the nursing home in the event the patient becomes Medicaid eligible."

During the 90 day period after the issuance of the Advisory Notice, counsel for Appellants and for the Health

Facilities Association of Maryland ("HFAM") engaged in correspondence with Attorney General Sachs in an attempt to obtain clarification of the scope and effect of both the Advisory Notice and the Attorney General's advice of counsel letter. During the same 90 day period, certain nursing home members of HFAM were inspected by State authorities and were cited for their failure to delete private pay duration of stay agreements from their contracts.

Appellant nursing homes and other members of HFAM have advised the State that they will continue to employ the one year private pay duration of stay agreements because they do not violate State or Federal law. Subsequent to receipt of that advice from the nursing homes, the State announced sanctions against certain nursing homes, cutting off Medicaid reimbursement to these homes for alleged violation of Federal law as interpreted in the Advisory Notice. This appeal followed the imposition of the santions.

All sanctions have been stayed pending this decision.

This action concerns duration of stay agreements entered into between nursing homes and individuals, or parties responsible for the individuals, who present themselves to the facilities as private pay patients. All parties have stipulated that private pay duration of stay agreements are entered into with individuals who are on private pay status on the day of their admission to the facilities. At such time, there is no assurance, and indeed no way of knowing, whether the patient will ever be eligible for Medicaid benefits.

A typical duration of stay agreement was employed by Sykesville Eldercare Center. Under such an agreement, the parties to the contract agree that the patient may elect to have his care paid for by Medicaid only after a certain period of

time, typically one year. The agreement assumes that the patient will have a continuing need for the level of care furnished by the facility beyond the one year period.

It is Appellants' position that nothing in the Federal statute invalidates such a private pay duration of stay agreement entered into voluntarily by both parties.

As a result of this difference of opinion, suit was filed in Federal Court by the Appellants. Judge Ramsey abstained from taking jurisdiction over the case, since there was a State process available that could prvide relief.

On March 11, 1983, oral argument was made in this State administrative forum in addition to the submission of briefs and exhibits by both the Appellant and Appellee. Additionally, the Appellants submitted copies of all documents submitted for review by Judge Ramsey.

Prior to said oral argument on March 11, 1983, both Appellant and Appellee agreed that both the Secretary of the Department of Health and Mental Hygiene, and, therefore, myself are not "per se" bound by the three-signature Attorney's General advice of counsel letter, dated July 7, 1982.

ISSUES

1. May nursing homes in the State of Maryland enter into private pay duration of stay agreements with individuals who are on private pay status (persons who are not certified for receipt of Medicaid benefits whether or not they are eligible for such benefits) as of the day they sign the admission agreement?

2. If the answer to issue number one is yes, can the private pay duration of stay agreements be enforced if and when the patient becomes eligible for receipt of Medicaid benefits and chooses to receive those benefits.?

FACTS

On July 9, 1982, John L. Green, Deputy Secretary for Operations of Health and Mental Hygiene for the State of Maryland, issued and distributed to all nursing homes in Maryland certified as Medicaid providers a Nursing Home Advisory Notice, and attached to said Notice an advice of counsel letter signed by two Assistant Attorneys General and Stephen H. Sachs, Attorney General for the State of Maryland, dated July 7, 1982.

During the 90 days following the issuance of the Advisory Notice, the Appellants and certain other nursing homes were inspected by State authorities.

This inspection consisted of review of contracts between the inspected nursing home and patients presently residing in such nursing homes.

Such contracts, which were investigated by the Agency, contained in one form or the other the provision that the patient may elect to have his care paid for by Medicaid only after a certain period of time, typically one year.

During this 90 day period of inspection, the nursing homes who were in violation of the Nursing Home Advisory Notice were sanctioned by the State of Maryland by being cut off from Medicaid reimbursement. Such sanctions were issued by the State of Maryland only after the individual nursing home refused to change the contracts between themselves and the patient to bring them into conformity with the July 9, 1982 Nursing Home Advisory Notice.

LAW & REGULATIONS

Section 1909(d)(2)(A) of the Social Security Act, 42 U.S.C. §1396h(d)(2)(A), provides that:

> "Whoever knowingly and willfully . . . charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this title, any gift, money, donation, or other consideration (other than a charitable, religious, or philantrhopic

> contribution from an organization or from a person unrelated to the patient) . . . as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility . . shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both."

The U. S. District Court for the District of Maryland noted in Ratino v. Medical Service of the District of Columbia, Civil Action No. R-79-952, 1981-1 Trade Cas. 64,144 (June 30, 1980), such a contract may be void as against public policy. In quoting from the decision of the Circuit Court of Appeals for the District of Columbia in Williams v. Walker-Thomas Furniture Co., 350 F.2d 445, 449 (D.C. Cir. 1965), the Court noted that:

> "[W]here a party of little bargaining power, and hence little real choice, signs a commercially unreasonable contract . . . the Court should consider whether the terms of the contract are so unfair that enforcement should be withheld."

As explained by Representative Pepper during floor consideration of this amendment, there is no meaningful bargaining possible between the patient seeking admission and the home. The patient is told to "take it or leave it." He can agree to the terms or go without medical care. Under such circumstances, as Representative Pepper noted, the contract is nothing less than "blackmail." 123 Cong. Rec. 30,531 (1977).

Under the Supremacy Clause of the United State Constitution, any State statute that is inconsistent with a validly enacted Federal law is void. Article VI, clause 2 of the United State Constitution provides that:

> "This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding."

See Carleson v. Remillard, 406 U.S. 598 (1972); Townsend v. Swank, 404 U.S. 282 (1971); Graham v. Richardson, 403 U.S. 365 (1971).

This requirement is paralleled in Article 2 of the Declaration of Rights to the Constitution of Maryland. That provides that State law cannot authorize conduct prohibited by Federal law.

42 C.F.R. 447.15 provides that:

> "A State plan must provide that the medicaid agency must limit participation in the medicaid program to providers who accept, as payment in full, the amounts paid by the agency."

This provision is paralleled in the State regulations for nursing homes at COMAR 10.09.10.03I and 10.09.11.03E.

As Sutherland explains in his treatise, Statutory Construction (4th ed. 1974), at Volume 3, §59.06:

> "The rule that penal or criminal statutes are given a strict construction is not the only factor which influences the interpretation of such laws; instead, the rule is merely one among various aids which may be useful in determining the meaning of penal laws. [Citations omitted.] This has been recognized time and again by the decisions, which frequently enunciate the principle that the intent of the legislature or the meaning of the statute, must govern and that a strict construction should not be permitted to defeat the policy and purposes of the statute."

This rule has been consistently applied by the United States Supreme Court. For example, in Scarborough v. United States, 431 U.S. 563 (1977), the Supreme Court affirmed a conviction over a petitioner's challenge to a judicial construction of the Omnibus Crime Control and Safe Streets Act of 1968. The Court agreed that the statute had been ambiguously drafted and that it was difficult to conclude which clauses were modified by a subsection of the bill. However, the Court concluded that any ambiguity was eliminated by reference to the legislative history of the provision. As the Court explained:

> "[P]etitioner seeks to invoke the two principles of statutory construction relied on in Bass - lenity in construing criminal statutes and caution where the federal-state balance is implicated. Petitioner, however, overlooks the fact that we did not turn to these guides in Bass until we had

> concluded that "[a]fter 'seizing every thing from which aid can be derived,' . . . we are left with an ambiguous statute.: 404 U.S., at 347, 92 S. Ct., at 522. The principles are applicable only when we are uncertain about the statute's meaning and are not to be used "in complete disregard of the purpose of the legislature." [Citations omitted.] Here, the intent of Congress is clear."

Id., at 577. In the instant case, that ambiguity can be properly resolved by reference to the legislative history and the construction intended by Congress in adopting the Pepper Admendment.

Similarly, in Bifulco v. United States, 447 U.S. 381 (1980), the Court considered the legislative history of the criminal statute at issue in order to determine the appropriate construction to be given the penalty provisions of the Comprehensive Drug Abuse Prevention and Control Act of 1970. In rejecting the government's interpretation of the statute in that case, the Court concluded that rather than supporting the government's view, "the Act's legislative history supported[ed] the opposite view." Id., at 398. By contrast, in the instant situation, the legislative history unambiguously requires the interpretation applied by the State Appellees.

The "Patient's Bill of Rights," 42 C.F.R. §442.311 (1981), provides that:

> "The ICF must have written policies and procedures that insure the following rights for each resident:
>
> (c) Transfer or discharge. Each resident must be transferred or discharged only for -
>
> (1) Medical reasons:
>
> (2) His welfare or that of the other residents; or
>
> (3) Nonpayment except as prohibited by the medicaid program."

Maryland law clarifies this last provision by indicating that reliance by an individual on Medical Assistance reimbursement as his source of payment for nursing home care cannot be considered

as nonpayment. Health General Article, §19-345(c)(1)(ii), Annotated Code of Maryland (1982), provides that:

> "A Medicaid certified facility may not [t]ransfer or discharge a resident involuntarily because the resident is a Medicaid benefits recipient."

Federal law requires all providers participating in the Medical Assistance Program to accept Medical Assistance payments as payment in full for the cost of services provided to Program recipients. 42 C.F.R. §447.15 (1981) provides that:

> "A State plan must provide that the medicaid agent must limit participation in the medicaid program to providers who accept, as payment in full, the amounts paid by the agency."

This provision is paralleled in section 1909(d)(1), 42 U.S.C. §1396h(d)(1). This section provides that:

> "Whoever knowingly and willfully charges, for any service provided to a patient under a State plan approved under this title, money or other consideration at a rate in excess of the rates established by the State shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both."

CONCLUSION

It is alright for the nursing homes in the State of Maryland to enter into private-pay duration of stay agreements with individuals who are on private-pay status (persons who are not certified for receipt of Medicaid benefits) as of the day they sign the admission agreement if said agreement would not restrict an individual in any form from the using or applying for Medicaid.

Additionally, I am pursuaded that having a provision in a private-pay contract between patients and the nursing home, stating in essence that the patient may elect to have his care paid for by Medicaid only after a certain period of time, typically one (1) year, is improper. Any attempt to enforce such agreements by any nursing home is illegal, notwithstanding an

agreement to the contrary. It is obvious that mentioning Medicaid in these agreements places the citizens of the State of Maryland in an unequal bargaining position with no clear choices if they wish to be admitted to a nursing home.

Any provisions in an agreement between a nursing home and a citizen of the State of Maryland referring to a waiting period before a patient in a nursing home may become eligible for Medicaid is void Ab Initio. The rationale in the advice of counsel letter of Attorney General Sachs is hereby adopted.

RECOMMENDATION

Based upon the Findings of Fact, Law and Conclusions in this case, it is my recommendation that an order be passed stating the following:

1. Nursing homes in the State of Maryland may enter into private-pay duration of stay agreements with individuals who are on private-pay status (persons who are not certified for receipt of Medicaid benefits, whether or not they are eligible for such benefits) as of the day they sign the admission agreement if said agreement would not restrict an individual in any form from using or applying for Medicaid.

2. Having a provision in a private-pay contract between patients and the nursing home stating in essence that the patient may elect to have his care paid for by Medicaid only after a certain period of time, typically one (1) year, is improper. Any attempt to enforce such agreements by any nursing home is illegal, notwithstanding an agreement to the contrary.

3. Any provisions in an agreement between a nursing home and a citizen of the State of Maryland referring to a waiting period before a patient in a nursing home may become eligible for Medicaid is void Ab Initio.

Steven M. Vogelhut, Esquire
Hearing Examiner
Office of Hearings

Attachment 6

SUMMIT NURSING HOME	*	BEFORE THE SECRETARY'S DESIGNEE
FREDERICK VILLA NURSING	*	MARSHA R. GOLD, Sc.D.
CENTER	*	DIRECTOR, POLICY ANALYSIS AND PROGRAM EVALUATION
AND	*	DEPARTMENT OF HEALTH AND MENTAL HYGIENE
SYKESVILLE ELDERCARE CENTER	*	HEARING OFFICE DOCKET NOS.
Appellants	*	82-MAP-264
v.	*	82-MAP-273
MEDICAL CARE PROGRAMS	*	82-MAP-274
DEPARTMENT OF HEALTH	*	83-MAP-7, 8, 9, 10, 36, 37, 38, 39, 48, 78, 93, 94,
AND MENTAL HYGIENE	*	
Appellee	*	

* * * * *

FINAL DECISION AND ORDER
OF THE SECRETARY'S DESIGNEE

I. Introduction:

This is the Final Decision of the Secretary's Designee in an appeal brought pursuant to Maryland Annotated Code, Article 41, §253, by Summit Nursing Home, Frederick Villa Nursing Center, and Sykesville Eldercare Center ("Appellants") from a decision of the Medical Care Programs, Department of Health and Mental Hygiene ("MCP") to suspend or withhold further Medicaid reimbursements.[1] The Appellants appealed the decision of the

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[1]A motion was granted to consolidate for purposes of this appeal the cases of Meridian Health Care, 83-MAP-7; Bel-Air Convalescent Center, Inc., 83-MAP-10; Holly Hill Manor, 83-MAP-8; Edgewood Convalescent and Nursing Home, 83-MAP-48; Greater Laurel Nursing Home, Inc., 83-MAP-37; Valley View Nursing Home, 83-MAP-38; Valley Nursing and Convalescent Center, 83-MAP-36; Perring Parkway Nursing Home, 83-MAP-39; Meridian Health Care, 83-MAP-78; Annapolis Convalescent Center, Inc., 83-MAP-93; North Arundel Nursing and Convalescent Center, Inc., 83-MAP-94; Regency Nursing and Rehabilitative Center, 83-MAP-9. Thus, this administrative decision applies to all of the above-mentioned cases; the issues Cont'd

MCP to the Secretary and a hearing was held before a Hearing Examiner who has submitted Findings of Fact, Law and Regulation, and Conclusions and Recommendations (the "proposed decision") which uphold the actions of the MCP.

This appeal is before the Secretary's Designee Marsha R. Gold, Sc.D., who was advised by Varda N. Fink, Esquire, Assistant Attorney General. The nursing homes contend that the proposed decision of the Hearing Examiner is not in accordance with applicable state and federal law. The Appellants have filed six specific exceptions to the proposed decision, each of which is addressed herein.

I have reviewed the record, the Hearing Examiner's proposed decision, the documents and arguments filed by the parties, and the oral arguments presented to me. Based on the full record of this case I have concluded that although the Hearing Examiner's Recommendation 1 is incorrect, Recommendations 2 and 3 are correct and are upheld.

II. Procedural History:

On July 9, 1982, John L. Green, Acting Secretary, Department of Health and Mental Hygiene for the State of Maryland (the "Respondent") issued a Nursing Home Advisory Notice which was distributed to all those nursing homes in Maryland which are certified as Medicaid providers. Attached to the Advisory Notice was an advice of counsel letter issued by the Office of the Attorney General. The Advisory Notice stated in relevant part:

> "1. Nursing home operators may not require individuals and/or their families to sign contracts agreeing to pay private-pay rates for a specified period before converting to Medical Assistance coverage. Federal law supercedes the Maryland Statute on this subject and Article 43, Section 565C(a)(18)(v)

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of fact and law are identical to those in 82-MAP-264, 82-MAP-273, and 82-MAP-274.

> cannot be given legal effect with regard to nursing homes participating in the Medicaid Program."[2]

The notice required all nursing homes to take corrective action within 90 days. During the 90 days certain nursing homes were inspected by Department authorities in order to determine whether contracts of these homes contained private pay duration of stay residency clauses. Those nursing homes whose contracts contained such clauses were cited for the failure to delete them from their contracts.

Appellants have not deleted the duration of stay residency clauses from their contracts. They have, in fact, advised the Department that they will not delete the clauses from current contracts and will continue to incorporate such clauses into future contracts with patients entering their respective nursing homes.

Because they have refused to delete the clauses, the Department pursuant to COMAR 10.09.10.16 and 10.09.11.16 notified Appellants that further Medicaid reimbursements would be withheld or suspended.[3] The instant appeal followed the imposition of

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[2]Another section of the Advisory Notice which is pertinent to the enforcement of duration of stay contracts, and thus to this case was: "4. Nursing home operations may not discharge a resident on grounds that are not enumerated in 42 C.F.R. §§405.1121 (K)(4) and 442.311. ((1) Medical reasons; (2) His welfare or that of the other residents; or (3) Non-payment. Payment as a Medical Assistance recipient may not constitute non-payment).

[3]COMAR 10.09.10.16 and 10.09.11.16 state in pertinent part:

> If the Department determines that a provider ... has failed to comply with applicable federal or State laws or regulations, the Department may initiate one or more of the following actions against the responsible party:
>
> (1) Suspension from the Program;
>
> (2) Withholding of payment by the Program;
>
> (3) Removal from the Program;
>
> (4) Disqualification from future participation in

Cont'd

these sanctions. All sanctions have been stayed pending the issuance of a Final Decision of the Secretary.

The appeal of the MCP action was initially heard by a hearing examiner at a hearing held on March 11, 1982. The Hearing Examiner has issued a proposed decision in which the following Recommendations are made:

> 1. Nursing Homes in the State of Maryland may enter into private-pay duration of stay agreements with individuals who are on private-pay status (persons who are not certified for receipt of Medicaid benefits, whether or not they are eligible for such benefits) as of the day they sign the admission agreements if said agreements would not restrict an individual in any form from using or applying for Medicaid.
>
> 2. Having a provision in a private-pay contract between patients and the nursing home stating in essence that the patient may elect to have his care paid for by Medicaid only after a certain period of time, typically one (1) year, is improper. Any attempt to enforce such agreements by any nursing home is illegal, notwithstanding an agreement to the contrary.
>
> 3. Any provision in an agreement between a nursing home and a citizen of the State of Maryland referring to a waiting period before a patient in a nursing home may become eligible for Medicaid is void Ab Initio.

Appellant nursing homes have filed written exceptions to these Recommendations. Oral arguments on the exceptions were heard before me on September 14, 1983.

III. Discussion

A. Nature of the Dispute

This appeal concerns duration of stay agreements entered into between nursing homes and individuals, or parties responsible for the individuals, who present themselves to the facilities as private pay patients. All partics have stipulated that private pay duration of stay agreements are entered into with individuals who are on private pay status on the day of

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> the Program, either as a provider or as a person providing services for which Program payment will be claimed.

their admission to the facilities. At such time, there is no assurance, and indeed in some cases no way of knowing, whether the patient will ever be eligible for Medicaid benefits.

The language of duration of stay agreements varies. The substance of the agreement is that the nursing home agrees to retain a patient who enters as a private pay patient when that patient converts to Medicaid, only if the patient has been in private pay status for a period of time, typically one year. For example, Summit Nursing Home utilizes the following clause:

> "I/we also understand and agree that if, at some future date _____ obtains coverage under Title XIX (Welfare-Medicaid), and the Summit Nursing Home has no beds available for Medicaid patients, it becomes my/our responsibility to move the patient to another facility."

Additionally, Summit distributes a "Patient Manual" which contains the following condition:

> "The Summit Nursing Home has set a limit on the number of beds assignable to Title XIX (Medicaid) patients, and that each of those beds is currently filled. If it becomes necessary to obtain coverage under Title XIX (Medicaid) within less than one (1) year from time of admission, it becomes the responsibility of the patient's family or representative [sic] remove the patient from the Summit."[4]

It is Appellants' position that nothing in the federal statutes invalidates such a private pay duration of stay agreement entered into voluntarily by both parties. On the other hand, Appellees contend that by the use of such agreements, appellant nursing homes have failed to comply with applicable

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[4]The Frederick Villa Nursing Center uses the following duration of stay clause:

> "If, after being in the nursing home as a private patient for one year, the patient is accepted as a Medical Assistance patient with a level of care for which the nursing center is licensed, the nursing center agrees to keep the patient under the Medical Assistance Program."

The Sykesville Eldercare Center contract refers to the facility's agreement to admit or accept patients under Medical Assistance after a period of months during which the patient pays privately.

Federal and State laws and regulations, and are therefore subject to sanctions under COMAR 10.07.10.16 and 10.09.11.16.

B. Issues

1. May nursing homes in the State of Maryland enter into private pay duration of stay agreements with individuals who are on private pay status (persons who are not certified for receipt of Medicaid benefits whether or not they are eligible for such benefits) as of the day they sign the admission agreement?

2. If the answer to issue number one is yes, can the private pay duration of stay agreements be enforced if and when the patient becomes eligible for receipt of Medicaid benefits and chooses to receive those benefits?

C. Law and Regulations

The statutes and regulations relevant to this Decision are set forth below.

Section 1909(d) of the Social Security Act, 42 U.S.C. §1396h(d) provides:

> (d) Whoever knowingly and willfully -
>
> (1) charges, for any services provided to a patient under a State plan approved under this subchapter, money or other consideration at a rate in excess of the rates established by the State, or
>
> (2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this subchapter, any gift, money, donation, or other consideration (other than a charitable, religious or philanthropic contribution from an organization or from a person unrelated to the patient) -
>
> (A) as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or
>
> (B) as a requirement for the patient's continued stay in such a facility,

> when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan,
>
> shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

This federal statute has been construed by the Hearing Examiner to prohibit the practice permitted under Maryland law by Health General Article §19-345(c)(1)(i) of the Annotated Code which provides:

> (1) A Medicaid certified facility may not:
>
> (i) Include in the admission contract of a resident any requirement that, to stay at the facility, the resident continues as a private pay resident for more than 1 year, if the resident becomes eligible for Medicaid benefits.

Clearly Health General §19-345(c)(1)(i) does not prohibit nursing homes from requiring entering patients to agree to duration of stay agreements of up to one year.

The regulations listed below are also relevant to this decision:

(1) Payment in Full Provisions
42 C.F.R. §447.15
COMAR 10.09.10.03E and I

(2) Patients' Bill of Rights -
42 C.F.R. §405.112 (K); 42 C.F.R. §442.311

D. Analysis

In his proposed Decision the Hearing Examiner concluded that duration of stay clauses are prohibited by 42 U.S.C. §1396(d)(2)(A).[5] The Appellants have contended throughout these proceedings that this federal statutory provision is inapplicable because the provision applies only to a patient who enters a facility as a Medicaid patient. Based on my analysis of the provision and its legislative history, it is my opinion that

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[5]The same analysis and conclusion is contained in the July 7, 1982 advice of counsel letter.

Appellants are correct in their interpretation of §1396h(d)(2)(A).[6]

However, the practice of requiring an entering patient, as a condition of remaining in a facility, to agree that for a specified period of time he/she will pay at the private pay rate, irrespective of the fact that the patient may become eligible for Medicaid during that time, is prohibited by other provisions of law. While §1396h(2)(A) does not prohibit such clauses, §1396h(2)(B) makes it a felony to charge an amount in excess of the Medicaid rate "as a requirement for the patient's continued stay in... a facility" when the cost of services to the patient is paid by Medicaid. Thus, once a patient applies to be and is certified as a Medicaid recipient, it is illegal to continue to insist that the patient pay at the higher, private pay rate as a condition of the patient's continued stay in the facility.

As a result of §1396h(d)(2)(B), Appellants can not legally enforce a duration of stay clause against a patient who becomes certified as a Medicaid enrollee. Although a private pay patient may be required as a condition for his/her continued stay to pay at the higher rate, Appellants may not legally require a patient who obtains Medicaid certification to do so.

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[6]The Hearing Examiner determined that the legislative history of the provision requires that it be read as follows:

> Whoever knowingly and willfully . . . charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this title, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient) . . . as a precondition of admitting a patient to a hospital, skilled nursing facility or intermediate care facility . . . shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

This analysis is specifically rejected.

Furthermore, federal law requires that all providers participating in the Medical Assistance Program accept Medicaid payments as payment in full for the cost of services provided to Medicaid recipients. 42 C.F.R. §447.15 provides:

> A state plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency. [emphasis See also, COMAR 10.09.10.03E and I.

In fact, §1909(d)(1) of the Social Security Act, 42 U.S.C. §1396h(d)(1) makes it a felony to charge a Medicaid patient at a rate in excess of the Medicaid rate.

Similarly illegal and unenforceable are Appellants' express and implied threats to discharge patients who convert to Medicaid before the lapse of time specified in duration of residency clauses. In order to participate in the Medicaid program as providers of nursing home services, Appellants must meet certain federal nursing home standards. See 42 C.F.R. §442.202 (Skilled Nursing Facilities) and 42 C.F.R. §442.250 (Intermediate Care Facilities). These standards in the so-called "Patients' Bill of Rights," apply to all patients in Medicaid certified nursing homes, regardless of private or public pay status. 42 C.F.R. §405.1121(K) (applicable to Skilled Nursing Facilities) requires that:

> "The governing body of the facility establish[es] written policies regarding the rights and responsibilities of patients and, through the administrator, is responsible for development of, and adherence to, procedures implementing such policies...
>
> These patients' rights policies and procedures ensure that, at least, each patient admitted to the facility: ...
>
> (4) Is transferred or discharged only for medical reasons, or for his welfare or that of other patients, or for non-payment of his stay (except as prohibited by titles XVIII or XIX of the Social Security Act).

Maryland law clarifies this last provision by indicating that reliance by an individual on Medical Assistance reimbursement as his/her source of payment for nursing home care cannot be considered as nonpayment.[8]

Therefore, violation of a private pay agreement is not a permissible basis for transfer or discharge of a patient under Federal law since it is not one of the three enumerated grounds for involuntary transfers or discharges in the "Patients' Bill of Rights." A nursing home cannot legally take such an action against a patient who converts to Medical Assistance reimbursement during a private pay period. The provisions of the "Patients' Bill of Rights" are not waiveable by individual patients.[9] They are absolute legal obligations owed to the State and Federal Governments as conditions for the facilities' continued participation in the Medicaid program.

Thus, Appellants cannot enforce duration of stay clauses against patients who become eligible for and are certified as Medicaid recipients. Any effort to enforce such a

---

[7]The equivalent section of the "Patients' Bill of Rights applicable to Intermediate Care Facilities is as follows:

> The ICF must have written policies and procedures that insure the following rights for each resident: --
>
> (c) Transfer and discharge. Each resident must be transferred or discharged only for--
>
> (1) Medical reasons;
>
> (2) His welfare or that of the other residents; or
>
> (3) Nonpayment except as prohibited by the Medicaid program.

[8]Health-General Article, §19-345(c)(1)(ii), Annotated Code of Maryland (1982) provides that, "A Medicaid certified facility may not [t]ransfer or discharge a resident involuntarily because the resident is a Medicaid benefits recipient."

[9] See Glengariff Corp v. Snood, et al., §§33,605 C.C.H. Medicare and Medicaid Guide at 3907 (N.Y. S. Ct., Nassau County, 1984).

clause through removal of the patient from the nursing home or through an action to seek the difference between the private pay and Medicaid rates would not only violate federal regulations but would also be a violation of 42 U.S.C. §1396(h)(2)(B). While Health General §19-324(c)(i) does not prohibit such clauses if they are for no more than year in duration, such clauses conflict with Federal regulations and statutes making enforcement of such clauses illegal.

Under such circumstances the continued use of such clauses is deceptive and misleading.[10] The only purpose for including such an unenforceable clause in a contract with an entering patient is to induce the patient to believe that during the first year of residence, despite eligibility he/she is prevented from applying for Medicaid benefits. The patient is unlikely to know that the clause is unenforceable.

Facilities certified to participate in the Medicaid program are required by the "Patients' Bill of Rights" to have written policies and procedures which insure that each patient is "fully informed before or at the time of admission, of his rights and responsibilities and of all rules governing resident conduct," 42 C.F.R. §442.311. Appellants' duration of stay clauses not only fail to fully inform patients of their rights but also mislead the patients' for Appellants' own financial benefit. Thus, they violate the "Patients' Bill of Rights."[11]

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[10]In fact, the use of these clauses violates the State's Consumer Protection Act. Commercial Law Article, §13-301, Annotated Code of Maryland (1982) defines unfair or deceptive trade practices to include any "(1)... misleading oral or written statement... which has the capacity, tendency, or effect of deceiving or misleading consumers... (3) Failure to state a material fact if the failure deceives or tends to deceive." Such deceptive trade practices are prohibited by §13-303. The Consumer Protection Act is applicable to nursing homes and other health care institutions. 630 p. Att'y General 183 (1978).
Cont'd

Because such clauses are misleading, they are prohibited by 42 C.F.R. §442.311, the Patient Bill of Rights. Because they are unenforceable and therefore misleading they are also void as against public policy.[12] Patients entering nursing homes and their families are rarely in a position to bargain with the home about such clauses. Furthermore, they are unlikely to know that the clauses are unenforceable. See Ratino v. Medical Service of the District of Columbia, Civil Action No. R-79-952, 1981-1 Trade Cas. 64,144 (D. Md. 1981); Williams v. Walker-Thomas Furniture Co., 350 F.2d. 445, (D.C.Cir. 1965). The inclusion of such clauses is properly prohibited.

IV. Ruling on Exceptions

1. "As a result of the position adopted by the Attorney General's Office at oral argument, the Hearing Examiner placed undue reliance upon the position of the Attorney General as set forth in the advice of counsel letter dated July 7, 1982, to the prejudice of Appellants."

Exception is 1 DENIED.

Undue reliance has not been placed on the July 7, 1982 advice of counsel letter. In fact, the parties stipulated before the Hearing Examiner that the Secretary and the Hearing Examiner were not "per se" bound by the letter.

2. "Reference to the Supremacy Clause of the United States Constitution is only necessary or appropriate where state law and federal laws are irreconcilable. The applicable state and

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[11] Such clauses also violate 42 C.F.R. §§405.112(k) and 442.31 which requires the adoption of "written policies and procedures" that insure that patients are transfered or discharged only for specified reasons.

[12] See, Glengariff Corp v. Snood, supra.

federal laws in this case may be interpreted in a manner to avoid such conflict."

Exception 2 is **DENIED**

It is denied for the reason that although this is a correct statement of law it is not relevant to this decision which holds that duration of stay agreements are illegal because federal law prohibits the enforcement of such clauses. As a result their inclusion in patient contracts is misleading in violation of federal and state regulations and public policy.

3. "Contrary to the statements by the hearing officer, the legislative history of the applicable federal law is supportive of the interpretation urged by Appellants."

Exception 3 is **GRANTED** to the extent it refers to the Hearing Examiner's interpretation of 42 U.S.C. §1396h(d)(2)(A).

4. "Private-pay duration of stay agreements are not void or unenforceable merely because the patients to the agreements may have unequal bargaining power."

Exception 4 is **DENIED** for the reasons set forth in this decision.

5. "State and federal provisions regarding payment in full and transfer or discharge prohibitions do not apply where patients have voluntarily agreed to remain private-pay patients."

Exception 5 is **DENIED** for the reasons set forth in this decision.

6. "The Hearing Examiner's recommendation number one is internally inconsistent."

Exception 6 is **GRANTED**

ORDER

Based on the review of the record in this case, the exceptions which were filed and the arguments of counsel, it is this 3 day of July, 1984:

ORDERED that a nursing home in the State of Maryland may enter into a private-pay agreement with an individual who is on private-pay status (a person who is not certified for receipt of Medicaid benefits, whether or not eligible for such benefits) as of the day the admission agreement is signed if the agreement does not restrict an individual in any form from applying for Medicaid; and it is further

ORDERED that having a provision in a private-pay contract between a patient and the nursing home stating in essence that the patient may elect to have his/her care paid for by Medicaid only after a specified period of time of up to one (1) year, is improper. Any attempt to enforce such agreements by a Medicaid certified nursing home is illegal, notwithstanding an agreement to the contrary; and it is further

ORDERED that any provision in an agreement between a nursing home and a patient referring to a waiting perior before the patient in a nursing home may apply for Medicaid benefits is void Ab Initio.

Secretary of Health and Mental Hygiene

by _____
Marsha R. Gold, Sc.D.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 8 day of May, 1984 a copy of the foregoing Final Order was mailed to:

Sanford V. Teplitzky, Esquire
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Secretary of Health and Mental Hygiene
201 West Preston Street
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William F. Clark, Esquire
Chief Hearing Examiner
Office of Hearings
300 West Preston Street
Baltimore, Maryland 21201

Marsha Gold
Marsha Gold, Sc.D.
Designee of the Secretary

Attachment 7

Prevalence of Private Payment Contracts

	July 1982	September 1984
Number of Facilities Participating in Medicaid	179	185
Number of Triple Certified Beds	9,649	9,729
Total Number of Medicaid Beds	21,166	22,216
Number of Facilities Requiring Private Payment	44	24
Percentage of Total	25%	13%
Number of Triple Certified Beds	2,784	2,168
Percentage of Total Triple Certified	29%	22%
Total Number of Medicaid Beds	6,657	3,185
Percentage of Total All Medicaid Beds	31%	14%

Appendix 6

STATE OF NEW YORK
DEPUTY ATTORNEY GENERAL
FOR MEDICAID FRAUD CONTROL
270 Broadway, New York, N.Y. 10007
(212) 587-5250

EDWARD J. KURIANSKY
Deputy Attorney General

August 21, 1984

Mr. David Schulke
United States Senate
Special Committee on Aging
Dirksen Office Building, Room G33
Washington, D.C. 20510

Re: "Medicaid Discrimination"

Dear Mr. Schulke:

Ms. Barbara Zelner, Medicaid Fraud Counsel with the National Association of Attorneys General, has asked me to respond to your inquiry regarding the problems encountered by state Medicaid Fraud Control Units in enforcing 42 U.S.C. section 1396h(d).

As a state prosecutor, I, of course, have no authority to prosecute criminal violations of the United States Code itself. However, largely as the result of a New York County grand jury investigation, conducted by this Office several years ago, concerning the practice by certain voluntary nursing homes of exacting "contributions" from prospective Medicaid patients, the New York Legislature in 1982 enacted a felony penal statute--nearly identical to the federal law--as part of section 2805-f of this State's Public Health Law. (I would note, parenthetically, that your Committee may wish to survey other states to ascertain how many have actually passed laws parallel to the federal statute.) Our overall experience in investigating this abuse and in seeking to enforce the new State statute may perhaps be of some interest to you.

We have found that the single most significant impediment to the successful prosecution of institutional providers for soliciting unlawful payments from Medicaid patients and their relatives has been the almost-uniform reluctance of these victims to come forward and testify. As a general rule, of course, "contributions" or other supplemental payments are solicited, and acceded to, only when the patient or his family is confronted with a scarcity of high quality long-term medical facilities or is in some fear that, even once admitted to a nursing home or hospital, the patient will not continue to receive the best possible care unless the demanded payment is made. These same understandable concerns naturally make the victims of such extortionate demands--typically the children of aged and infirm parents--unwilling to testify against the unscrupulous providers who possess an almost life-and-death power over their parents. Even during our grand jury investigation, conducted under a guarantee of secrecy, family members were extremely reluctant to give evidence which they felt might compromise the admission or continued care of their parents if it were

revealed. As a possible method of alleviating this considerable evidence-gathering problem, I would urge the Congress to consider authorizing stringent criminal penalties for providers who threaten to, or do, retaliate against patients or prospective patients whose families report unlawful solicitations or otherwise cooperate with law enforcement authorities.

The major substantive obstacle to prosecution under state and federal laws, as they are now written, is that there appears to be no protection for patients who are manifestly eligible for Medicaid assistance but have not yet had the cost of their medical services, in the words of section 1396h(d), actually "paid for (in whole or in part) under the State plan." Taking advantage of this loophole, many private and voluntary nursing homes require patients who are plainly eligible for Medicaid to sign contracts under which the patient agrees to enter and remain as a "private" patient for a specific period of time--usually six months or a year--during which he or his family will be personally and exclusively responsible for a stated monthly payment in excess of the Medicaid rate. These contracts further purport to prohibit the patient from applying for Medicaid until the expiration of the "waiting period."

The unmistakable effect of these "private pay" contracts is to extract large sums of money for providing care to seriously ill persons whose limited financial resources would ordinarily qualify them for assistance under the Medicaid program--precisely the same predatory practice aimed at in section 1396h(d). Moreover, this discriminatory device works its greatest hardship on the very neediest--those who have no family or friends willing or able to pay the high cost of six month's or a year's nursing home care at private rates and who are thus forced to wait endlessly for scarce openings in marginal facilities. Although one court in this State has recently held such contracts to be unenforceable as against public policy, and both New York's and Maryland's Health Departments have now administratively prohibited providers from enforcing them, the deterrent threat of criminal prosecution is absent because the letter of the law is, at least arguably, complied with so long as no money is simultaneously taken from both the patient and the government. I would, therefore, recommend that the Congress consider amending section 1396h(d) to prohibit the request or receipt of money or other consideration from or on behalf of any patient who the facility operator knows or should know is eligible for Medicaid and also to make it unlawful to require any patient to "waive" his Medicaid eligibility or defer exercising his right thereto for any period whatsoever.

Finally, in addition to strengthening existing criminal statutes, you may also wish to consider various legislative approaches already taken by a number of states to reduce the incidence of Medicaid discrimination, such as rate equalization between private and public pay patients (Minnesota); requiring providers to make a minimum number of beds available for public pay patients (New Jersey); and requiring that patient admissions be handled on a first-come, first-served basis (Connecticut).

Please do not hesitate to contact me should you have any questions or desire any additional information.

Sincerely yours,

EDWARD J. KURIANSKY

EJK/ahs
cc: Richard Plymale, President
National Association of Medicaid Fraud Control Units

Barbara Zelner, Medicaid Fraud Counsel
National Association of Attorneys General

Appendix 7

STATE OF NEW JERSEY
OFFICE OF THE GOVERNOR
CN-001
TRENTON
08625

THOMAS H. KEAN
GOVERNOR

STATEMENT OF

THE HONORABLE THOMAS H. KEAN

GOVERNOR OF NEW JERSEY

BEFORE THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

ON

DISCRIMINATION AGAINST THE POOR AND DISABLED

IN NURSING HOMES

OCTOBER 1, 1984

Mr. Chairman and members of the United States Senate Special Committee on Aging, I appreciate the opportunity to discuss an issue of major concern to me and to so many of our elderly people and their families in New Jersey. This is the problem of private pay contracts being demanded by nursing homes as a condition of admission.

It is a cruel problem that our nation has neglected, but no longer can we turn our face away from such lack of fairness to our elderly, or to the humiliation of forcing their children to choose between the love for a parent and the balance in a checkbook.

It is an outrage that this sort of practice is allowed to continue and it is my sincere belief that states and the federal government should take stringent action to put an end to this selfish manipulation of our senior citizens and their families.

While we in New Jersey have taken a number of steps to reduce a persistent waiting list for nursing home beds through alternative home and community-based programs, we still have more than 2,600 Medicaid patients waiting for a bed. The use of private pay contracts had been instrumental in keeping this waiting list at a consistently high level.

Most New Jersey nursing homes now require that families, or the patient seeking admission, sign a private pay contract as a condition for admission and for subsequent acceptance of Medicaid benefits. Some of these contracts extend from three months to two years or more, during which time the nursing home can exact payments which most families can ill afford. Those patients without private pay contracts remain on the waiting list until a bed can be found. This wait can often last for months.

In 1983, I established a nursing home task force in New Jersey to address some of the questions surrounding long-term institutional care, including ways of increasing the nursing home bed supply and the question of available alternatives to nursing home care.

The task force found that the use of private pay contracts was quite prevalent for those who require long term institutional care, and recommended that this practice be stopped.

Accordingly, I proposed legislation to make it a criminal offense in New Jersey for a nursing home operator to require a Medicaid eligible patient, or his of her family, to sign a private pay contract as a condition of admission.

In my annual message to the State Legislature early this year, I stated that:

> "This predatory practice victimizes our elderly citizens and their families, and it is widespread throughout the state. It is nor uncommon for the families of senior citizens who want to enter a nursing home and who are eligible for Medicaid to be confronted with the demand that they sign a contract with much higher private patient rates."
>
> "In some cases, the terms of the contract require the payment of $2, 000 per month for two years, regardless of the length of actual stay. But they are exacted as a cost of gaining admission to the nursing home. This practice presents families with a cruel choice between providing care for a loved one and extraordinary financial sacrifice. It should be stopped now."

Private pay contracts affect nor only those awaiting placement, but those already in the nursing home. According to our nursing home task force report, an estimated 16 percent of nursing home patients whose families are paying privately are Medicaid eligible or potentially eligible.

Many families are exhausting their own much needed resources in order to keep their loved ones in a nursing home. These families are frequently harassed and threatened with court action if they do not honor the private pay contract.

The children of the very aged patient in the nursing home may themselves be elderly and with limited income and resources. According to a Government Accounting Affice report on the cost implications of entering a nursing home, more than 63 percent of the families of nursing home residents have incomes under $15,000. Without our intervention, we are seeing those elderly children of the very aged impoverishing themselves as a direct consequence of the private pay contract.

I would like to mention another problem that has a bearing on this issue. This problem centers on the admission of private pay nursing home patients who exhaust their resources for care that they may not have needed in the first place. Nursing homes, unlike hospitals, are not required to screen privately paying patients to determine if their care is even necessary or appropriate.

This contributes further to the problem of waiting lists when an admission is based less on the patient's need for nursing home care and more on the patient's ability to cover the costs of the care.

In New Jersey we attempted a partial solution to the problem by requiring through regulation that a Medicaid-approved nursing home could not discharge a Medicaid-eligible patient if that patient resided in and paid the nursing home privately for a period of six months. This regulation mandated that the nursing home keep the patient after funds have been exhausted and

accept Medicaid reimbursement. We also required under the State's Certificate of Need program that any new facility agree to allocate at least 35 percent of its beds to Medicaid patients as a condition for approval. These policies have required constant vigilance and monitoring. While they are important steps, they still have not resolved the major problem of the existence of private pay contracts.

We need a firm and clear federal policy on this issue, one that will protect the elderly and their families when the need arises for nursing home care. We need a coherent policy that recognizes the impact of the private pay contract on the patient and his or her family, and also recognizes the financial considerations of the nursing home industry.

We owe our seniors more than promises. We need to show them that we are taking action to make their lives better.

For their future, for our future as public servants committed to the public good, we must abolish the predatory practice of mandatory private pay contracts.

Thank you.

Appendix 8

STATEMENT OF GRETCHEN SCHAFFT
PRESIDENT OF GRETCHEN SCHAFFT ASSOCIATES, INC.
REGARDING RACIAL DISCRIMINATION IN U.S.
NURSING HOMES

There can be few topics as important as discrimination against the poor and disabled in nursing homes. I am pleased that my studies of racial integration in nursing homes in five East Coast cities, undertaken from 1978 - 1980, are relevant to your investigation.

Medicaid should provide access to quality long-term care to those among the elderly who are the most poor and sick. In my research, I found that this goal was only partially met. Under Medicaid law, the poor elderly may have their care paid for in nursing home institutions by a combination of federal and state funds. This allows for the appearance of great equity, but, in reality, can encourage a distinction to be drawn between the elderly who have known poverty for years and those who have recently exausted their financial resources. This distinction impacts most heavily on racial minorities and the disabled who are most likely to enter nursing home care with small savings, inadequate pensions, and multiple health care problems.

The difference between the nursing home residents who have private funds to cover their initial care in the facility and those who do not is often overlooked in discussions of equity of care. Accumulated assets will be liquidated over a period of time, ostensibly leaving all residents equally impoverished.[1] These residents will all need Medicaid support for their long term care.

However, for the nursing home industry, there is a dual market.[2] Private paying residents bring more profits and often a lower level of care. It is to the advantage of the proprietary and non-profit nursing home to encourage those who are able to pay privately, even for only some period of time, to become residents. Therefore, it can be a marketing tool for the facility to offer the prospect of an easy transfer to Medicaid payments after a certain number of months or years. It is also possible for the family of the resident to transfer assets during this period despite laws in some states that attempt to inhibit that practice.

The process of transferring from private pay to Medicaid is facilitated by the flexibility of the system. Eighty-seven percent of nursing homes are certified for either Medicaid, Medicare or both.[3] However, this does not mean that all the beds so certified must be in use under that financing. It is quite common for beds to be used by the nursing home for private paying residents. If no such resident is available for the bed, a Medicaid patient will then be given the place. In one compliance study conducted by the Office of Civil Rights, it was found that those facilities certified but not using Medicaid beds were those most likely to discriminate against minority patient admissions.[4]

Minority and poor people should not be denied access to any facility which provides care for the medically indigent. The Civil Rights Act of 1964 guarantees that. Yet, it is apparent that there are nursing homes which provide care under Medicaid payment to a selected clientele which includes few, if any, minority residents. How can this be?

School integration was the primary target of Title VI of the Civil Rights Act; integration of health facilities was only seriously addressed during the period of time just prior to the implementation of Medicare and Medicaid. As a result, desegregation of health care facilities has resulted in routine implementation of the law and has evinced little interest from enforcement agencies.

Federal responsibilities of the Office of Civil Rights evolved over the years to include four basic components. First,Title VI assurances from health facilities participating in Medicare and Medicaid are the responsiblity of this office. Second, Title VI compliance plans from state agencies are required to be submitted and approved. Third, the ultimate responsibility for investigating complaints and non-complying recipients of funds is vested in the Office of Civil Rights, although actual compliance work may be done at the state level. Fourth, Title VI "compliance reviews",or special studies of compliance patterns, are undertaken by the agency.

The Justice Department has been involved with Title VI since the inception of the Act. In the mid-1970s, its responsibilities were enlarged to include oversight of other agencies and to set standards for agency compliance with Title VI. At the time of my studies, the Justice Department had not reviewed any health care agency.

Despite the fact that the Justice Department collects Title VI complaints from the funding agencies, federal officials reported in my studies that there were few requests at the federal level to work on issues of compliance in the health care arena. These officials were aware of few procedures available to them to enforce compliance had there been complaints.

If nursing homes are often racially identifiable and appear to be excluding the people who do not have private funds for initial payments, why are there not more complaints? Reasons may be found, in part, in the implementation procedures. Every nursing home is checked for Title VI compliance before it receives federal funds and once a year thereafter. State offices provide this function, but the inspectors are often poorly trained. In my studies,it was discovered that files kept on compliance inspections were not checked, and evidence of non-compliance in the absence of specific patient originated complaints was ignored.

The requirements of Medicaid funding are such that a relatively high level of care is mandated for any patient so covered. This, in addition to the lower level of reimbursement for care, makes the Medicaid resident a high-cost, low-return patient for the nursing home. If such patients can be distributed among a largely private paying clientele, and if they have "earned" their Medicaid status through "apprenticing" as private patients, they can be accomodated. This results in averaging out expenditures among residents of different payment sources.[5]

The amount of staffing required by the residents of nursing homes affects the cost, of course. Residents needing skilled nursing care create additional expense for the home. If these residents are covered by Medicaid, care is often provided at a financial loss.

In order to attract private paying residents, non-governmental homes create an atmosphere that stresses the social-psychological model of care. Attractive decor, programs that are in tune with the socio-economic backgrounds of the clients, and resident services, such as beauty parlors and recreation rooms are usually prominent. In comparison, the public facilities stress a medical model and tend to provide few social amenities.

From the viewpoint of the nursing home resident and the family members, the facility that is located close to home is the most desired.[6] Neighborhood homes are usually smaller and more personal than public facilities. Transportation is likely to be adequate, making visiting more viable.

For the person who needs nursing home care and cannot afford an initial period of private payment, public facilities become the likely placement. The minority elderly are familiar with these nursing homes and often associate them with almshouses.[7] While medical care can be superior in public facilities, the appearance of the institutions is often unappealing. Transportation is often inadequate or unavailable on weekends.

When family members do not observe their loved ones in an institutional environment at regular, frequent intervals, personal care is likely to suffer. It is more difficult for government institutions to dismiss employees who are not doing a good job than it is for private facilities.

The result of economic incentives to nursing homes to attract low-care, private pay residents is a clustering of minority and high-care residents in certain facilities in most localities. Homes become racially identifiable, and a pervasive attitude of "deserving" and "undeserving" poor filters into the community. Referral patterns from doctors, social workers and ministers reflect racial steering of minorities into those facilities with high minority concentrations.[8]

There is obviously a mechanism for checking nursing homes for compliance, but there is no real enforcement of the equal access requirement. The sanctions available to encourage compliance are eitner too weak or too strong. The emphasis has always been on negotiation and attempting to bring about conciliation of vendors with the law. If this is unsuccessful, funds can be withdrawn, or,in the case of an initial award of funds, withheld. As a Washington official said:

> "The federal government is in a peculiar position because there are not enough providers of Medicare and Medicaid. They say, 'Please provide these services. They are needed.' But, on the other hand, 'We are going to regulate you if you do.'"

In my studies, I found that state officers in charge of compliance were candid in stating that they did not enforce guidelines of Title VI which state that nursing homes should utilize referral sources "in a manner which assures an equal opportunity for admission to persons without regard to race, color, or national origin in relation to the population of the service area". None of the state officers knew what was precisely meant by "service area". One officer said that referral agents, such as doctors, social workers, hospital discharge planners and community service workers "have a little trouble with Title VI because, in their best judgment, they feel that a black man would be more comfortable with other blacks." This kind of confusion and indecisiveness can occur because there are no specific guidelines for administering the enforcement activities.

None of the state offices visited in my studies had a written policy of action if a nursing home was found to be out of compliance. One Washington Office of Civil Rights official claimed that such records simply do not exist. Compliance reviews, however, are received by the Office of Civil Rights, and do indicate serious inequities in service provision.[9]

If enforcement officers are confused about the nature of compliance, nursing home administrators are as well. Eighteen percent of those nursing home administrators interviewed in my studies said that they did not know what was required of them under Title VI, and twenty-four percent said they did not know what sanctions would be imposed if they were not in compliance.

Certainly, the public is unclear about what facilities exist for their use. Interviews with families in five cities indicated that few were aware of the range of nursing homes in their community or which ones had Medicaid support. Citizens depend upon the expertise of community referral agents and are guided by them. Black families we interviewed most often mentioned the large, public institutions as places where their elderly would have to get care. Most expressed reluctance to take steps "to throw the old folks away". One can applaud the family centeredness of these people, but one must also remember that it reflects a smaller range of choice. Given the same referrals to proprietary and non-profit homes

as others in the community, they may have chosen to place a loved one closer to home in an attractive environment. It is clear that the delayed placement of the infirm elderly takes a toll on the caretaker which is often very serious.[10]

My studies clearly show overrepresentation of the black elderly in public nursing homes. Because of the stigma often attached to these institutions, the distance to be traveled to reach them, and the often unattractive physical environment which they afford, this cannot be claimed equal access under the law. Few complaints emerge from clients of the homes because they do not know that they are being denied access. They make the assumption that the private nursing homes are not available to them because of cost.

Indeed, if nursing homes are allowed to maintain a system of attracting private pay patients prior to assignment of Medicaid status, that assumption is correct. The initially poor cannot afford care in these homes.

It is clear that if the inequities of this system are to be alleviated a greater precision must be given to the interpretation of the Title VI guidelines as they apply to nursing homes. Racially homogeneous facilities should be looked at carefully during compliance reviews, and intermediate sanctions should be available to officers in charge of ensuring compliance. This might mean fines or citations rather than withdrawal of funds or closure.

Technical assistance to nursing home administrators in how to better serve their communities without regard to race, socio-economic class or degree of disability is also an important step. Public information to the consumer, at the same time, would encourage families to seek care to which they are entitled.

Investigation into the practice of "reserving" beds for the eventually impoverished at the expense of the initially poor must be more thorough. Sanctions against this behavior can also be developed which allow the continued operation of the facility while punishing those responsible.

Nursing homes provide an invaluable service to the community. Anyone who has needed their services knows that a well run facility is a blessing to the patient and the family. The nursing home industry is peopled by a majority of professionals who want to provide a community service. It is up to the government to see that the incentives for doing so, without regard to race or level of disability, are strengthened. The intent to discriminate may not enter into the practices which result in discrimination. Yet, when policies allow the discrimination to take place, and even encourage it through disincentives to provide equitable care, that discrimination becomes institutionalized. We need to take steps to ensure that that does not happen.

REFERENCES

1. U.S. Department of Health and Human Services, Health United States 1980, 81-1232, 1981: 93.

2. Scanlon, William J. "Nursing Home Utilization Patterns: Implications for Policy", Journal of Health Politics, Policy and Law, Vol.4, no 4, (Winter 1980) 1-31.

3. U.S. Health, Education and Welfare, National Center for Health Statistics, Series 13, no. 27, "Characteristics, Social Contacts and Activities of Nursing Home Residents U.S. 1973-1974,"1977.

4. U.S. Health Education and Welfare, "Baltimore City and Baltimore County Nursing Home Referral Study", Health and Human Services Branch, Office of Civil Rights, Region III, 1974.

5. Kosberg, J.I. "Differences in Proprietary Institutions Caring for Affluent and Nonaffluent Elderly". Gerontologist, Vol. 13, 1973: 299-304.

6. Schafft, Gretchen. "Nursing Homes and the Black Elderly" Final Report for AoA grant #90 A 1740 (01), Washington, D.C., 1979.

7. Schafft, Gretchen, "Nursing Home Care and the Minority Elderly", The Journal of Long Term Care Administration, Vol. VIII, no. 4 (Winter 1980) 1-31.

8. Schafft, Gretchen, "The Impact of Title VI of the Civil Rights Act on Nursing Home Integration in Three East Coast States" Final Report for AoA grant #90 AR 2072 (01).

9. U.S. Health, Education and Welfare,"Baltimore City and Baltimore County Nursing Home Referral Study" op.cit.

10. Maryland State Office on Aging. "Report to the General Assembly on the Family Support Demonstration Program", Baltimore, Maryland, August 1981.

Appendix 9

CASE HISTORIES OF VICTIMS OF DISCRIMINATION

TESTIMONY OF ANONYMOUS WITNESS

DEAR SENATOR HEINZ:

We placed our mother in a nursing home earlier this year. She is ninety years old and a widow for fifty-two years.

Two of my sisters cared for her in their homes as long as their health would permit, the rest of the family having to work full time. Placing her in a health care facility was an extremely difficult decision to make although obvious that it was necessary. A critical factor, however, was finding a facility which the family could feel comfortable with. Having discovered the "ideal" facility, negotiations began with the administrator. He told us that she would not be eligible for a Medicaid bed for one year. A few days later, he told us that he could reduce that requirement to nine months, but to be sure to keep that confidential. A few days later, he phoned to say that he would reduce that to six months, but that was the very best he would be able to do and that we were not to discuss it with anyone.

During the pre-admission conference with the administrator, I asked for an explanation of the private pay requirement. He said that the facility was built as a private pay and later it was decided that Medicaid beds would be made available on the condition that a one year private pay requirement be fulfilled. He made the point that he was making an extra special concession for our family. I then asked if we should make application for Medicaid presently. His reply was "Oh, no, wait until about the fifth month", and he would be glad to assist us with the application. On the day of admission, his representative drew up the contract which included the following exception: "The undersigned responsible party understands and agrees that the patient cannot be eligible for a Medicaid bed at our facility within (1) one year following admission". My sister who signed the contract, was afraid to question the one year stipulation or the six month final offer, since the administrator had forbidden her to discuss it with anyone.

A few weeks later, we read a newspaper article by Bill Stephens, Director of Legal Care Projects in Tennessee, stating that this requirement is a violation of federal law. I contacted Mr. Stephens and at his request, sent him a copy of the contract whiting out names and dates in order to avoid possible recriminations against my mother.

Subsequently, I was contacted by Senator Heinz's staff to see if I were willing to appear before the Committee. I consulted with the other members of my family and they were strongly opposed for fear of possible recriminations against our mother.

I feel obligated to honor their wishes although knowing that without testimony such as ours, these violations will likely continue, forcing financial crisis upon many who may be far less fortunate than we. It is in their behalf that I respectfully submit this anonymous testimony.

TESTIMONY OF ANONYMOUS WITNESS

DEAR SENATOR HEINZ:

My mother was placed in a New York convalescent hospital in February, 1984. It will be necessary to provide you with information about her background before we get involved in a chronological development of what happened to her in approximately the last eighteen months.

My mother was a resident of Brooklyn and had lived there throughout her married life. She had three children and was widowed in 1954. After my father died, she lived in Brooklyn, first alone, and then moving into an apartment with her sister. This was an apartment her sister had lived in approximately thirty-five years at the time my mother moved in with her. My mother had a series of accidents in which both hip sockets were removed and she was only mobile through the use of hand crutches. She was able to maintain herself fairly well up to the time she was eighty-five, or thereabouts. (She is currently eighty-seven.) At that time she had increasingly longer and longer stays in hospitals, based on pains in her legs or heart problems. Another problem was developing simultaneously with her physical debilitation. She and my aunt, who had gotten along beautifully throughout fifteen years of living together, were now fighting horribly. Each one accusing the other of being bossy and having periods of time in which their only communication was by crying and shouting.

My mother's doctor informed her that this constant uproar was not good for her blood pressure and strongly suggested that she remove herself from the household. My aunt, at the same time, was obviously having problems with memory and my mother was reluctant to leave her alone. It was a terrible problem of needing each other and yet needing to be separated from each other. When things worked well, my mother and aunt could function, keeping house, getting the shopping done and doing whatever was necessary to maintain themselves in the apartment, in a minimal fashion.

About two years ago, with the long hospital stays that my mother endured, it became very obvious that something had to be done. My sister and I investigated possibilities of individual apartments, and possibilities of placement in a senior citizen's apartment. We found that housing in New York was almost impossible to obtain; and that many senior citizen residential facilities only wanted people who were ambulatory when they arrived. Our problem was that we had not investigated this situation soon enough, thinking that the best place for our mother was where she wanted to be, which was at home.

In October, 1983, we attempted to find an alternative to my mother's return to the apartment. At the time this was not

possible and my mother herself sought help through Medicaid. Some time after October, 1983, my mother was placed on Medicaid in New York City and received Home Health Care and Homemakers to help her with her personal needs. This went on in an intermittent fashion since she was hospitalized off and on until June, 1983. At that time, my mother decided that she had to leave my aunt and move in with one ofher children. She flew to California in June, 1983, and resided with my sister in the North Bay Area until she had a mild stroke in January, 1984. After a short stay in the hospital and a one month stay in a rehabilitation center, she was placed in a nursing home since she had become incontinent and incompetent as well.

My sister conducted the search for a nursing home based on recommendations made by physicians and social workers at the Rehab Center. While in California, my mother had not applied for Medicaid. My sister, in searching for a nursing home, found that the one most highly recommended by physicians required that she sign a year's contract for private-pay and not make any waves about obtaining Medicaid. The cost of this home is approximately $1800 per month, which does not include incidental expenses which brings the cost up to approximately $2100 per month. My sister accepted the recommendations after visiting the home and placed my mother there. She refused to fight them on the requirement of private-pay for a year because she was concerned that the treatment my mother would get on Medicaid would be less than that she would receive as a private-pay patient and she was also concerned that they would not accept her in the home unless my sister accepted the contract. Everything that I tell you is information derived from conversation with my sister.

At present, my mother has been in the home for seven months, and according to the contract, would have to stay another five months at private pay before they will consider accepting her on Medicaid. This is getting increasingly difficult.

I wish to emphasize that although my mother was a Medicaid recipient in New York, the fear engendered in my sister by the nursing home's potential refusal to accept my mother as a patient or the fear that she would not get good treatment essentially forced acceptance of a one year contract for full private-pay. We are fortunate in that we could afford to protect our mother somewhat. I am concerned about people who have to accept nursing homes of dubious reputation or accept any place if an individual is on Medicaid. It is an awful thing to institutionalize a loved one, particularly when one is insecure about the treatment he or she will obtain.

TESTOMONY OF JUANITA CARRIER

DEAR SENATOR HEINZ:

My name is Juanita Carrier and I am 30 years old. During the early summer of 1982 it became evident that my father-in-law (hereafter referred to as Paul) would need to be moved into a nursing home. His health had been declining for a couple of years due to strokes and a severe case of hardening of the arteries. Paul was unable to walk without the use of a walker or someone's help. He was incontinent and showed signs of losing control of other bodily functions. He was able to feed and dress himself although both tasks took him quite some time. He was a happy, non-violent man.

Paul was living at home with his wife who was approximately 73 years old. Since her own health was poor she could not care for him any longer. On the advice from "Citizens for Better Care" and other people, we decided to check Paul into a hospital in hopes that a social worker there would have some influence with area nursing homes. We were told that nursing homes would accept a patient sooner if they came directly from a hospital. It did not work that way for us. Paul ended up back at home and the search was basically left up to his family. The following is a list of nursing homes I either called or visited during August and September of 1982.

o In August, 1982, I visited A. Convalescent and Nursing Home in Warren MI, and was told by the admittance director that they had three beds available for 1 year's private pay at $40 per day. After the year was ended they would then accept Medicaid, but not before.

o Also in August, 1982, I visited N.N. Nursing Home in Sterling Heights and was told by the admittance office that they could admit Paul within three to five days if we would pay privately for one year at a cost of $42 per day. After the year was ended they would then accept Medicaid.

o In Sept. 1982 I contacted F.A. Nursing Home in Armada, MI, by telephone and was told by a representative that they required one year's private pay before they would accept Medicaid.

o I also contacted by telephone C.C. Nursing Home in Mt. Clemens and in Warren, and was told that they both required six months private pay before they would accept Medicaid. I must add here that neither Paul or any of his children were financially able to pay a nursing home for his care. He would definitely have to be admitted as a Medicaid patient.

During the second week of September, 1982, I visited E. Nursing Home in Port Huron, MI. I had heard about the home through friends of family members and went to see it. Mrs. F. was in

charge of admitting and informed us that they had several beds available for Medicaid patients. It was a new facility and so far away that they were slow to fill all the beds. In fact it was an hour and 30 minutes drive by freeway from our house. While I was in Mrs. F.'s office she told me that E. Nursing Home had a facility in Detroit, about 15 minutes from our house. She offered to call that facility for me to see what they had available. She talked to a Reverend who said they had beds available but not "Medicaid beds". The way that Mrs. F. explained it was that periodically they would open their admittance to Medicaid patients. Once they received an undisclosed number of them they would "close off" admittance except to those who could pay privately. Since we had no other choice, we admitted Paul to the Port Huron facility even though it was so far from our homes. The greatest hardships were the middle of the night trips when nurses would call and advise us to come right away because they didn't think Paul would live through the night. Had Paul been at E.'s Detroit facility we could have spent much more time visitng him instead of so much time driving back and forth.

Even though Paul was admitted to E. on September 19, 1982, I didn't stop looking for a home that was closer to us. In November I visited A.W. Nursing Home in Warren and spoke to Mrs. M.. That facility was still under construction and was due to open some time in January, 1983. We had a good chance of getting Paul admitted since the waiting list was not very long. However, Mrs. Monden explained that they would only accept a "certain number" of Medicaid patients. After they had attained their quota of Medicaid patients you could only be admitted if you agreed to pay privately for one year at a cost that had not been determined at that point.

We decided to put Paul's name on their waiting list in hopes that he would be one of that "certain number" of Medicaid patients that they would accept. We never received a call from A.W.. As it turned out we didn't need their facility. Paul died on January 19th, 1983.

UTCHS THE UNIVERSITY OF TENNESSEE
Center for the Health Sciences

College of Medicine
Department of Family Medicine
Family Practice Center

MEMPHIS • KNOXVILLE • CHATTANOOGA • NASHVILLE • JACKSON

October 19, 1984

Mr. James Salvie
U. S. Senate
Special Committee on Aging
Room SD-G33
Washington, DC 20510

Dear Mr. Salvie:

Thank you for permitting me to participate in your efforts for our senior citizens. This letter will provide some of the information you requested when we talked by phone last week. I trust it will be of some help to you.

Several patients come to mind that have been delayed or refused admission into a nursing home because they were on Medicaid and not full pay, or their physical disabilities were such that they would require considerable nursing care. This has been so frequent that I thought it was a common practice with all nursing homes. In reflecting back, I can recall one facility in the community that has presented no particular difficulty in admitting patients. This facility has been a skilled care facility, and they have indicated to me that as of the first day of December this year, they will no longer be a skilled care facility. I talked with the administrator who said there were many reasons for making this change. The disallowance of their charges, the difficulty with keeping records, and the massive amount of guidelines that has been sent have made it impossible as well as a low financial return to continue in this type of service. This is going to create a health care crisis for those patients who need skilled care in our area since this is the last facility rendering that type of care in a community that has over 50,000 people and in a trade area that serves one-quarter million patients.

The first case that I would like to bring to your attention is Mrs. I.R. who is approximately 80 years of age, has severe congestive heart failure, organic brain syndrome, and mitral valvular disease. This lady had been in a facility and admitted to our hospital on two occasions due to dehydration, and in order to combat her dehydration and give her adequate caloric intake, the decision was made to insert a gastrostomy tube. This lady made phenominal improvement, became somewhat oriented and much easier to manage, and her quality of life was much improved. The problem we had was with the nursing home when they learned that she had had the gastrostomy tube placed. They gave the family and me considerable anxiety because they stated that they would not accept gastrostomy tubes into their facility which is an intermediate care facility. After pleading and negotiations, the lady was readmitted. Sometime later she developed congestive heart failure that was of acute nature, was hospitalized, and after a few days had recovered, but it was felt that she might need intermittent oxygen therapy. At this time the family was again told that they would have to seek a skilled care facility. After intervention by my partners and the family, the facility did take her back, and she is now doing well in this facility.

39-718 O - 84 - 14

Another patient that I would like to mention is a person who was admitted to our hospital on a neurosurgical service with transection of the cervical cord which rendered him a quadriplegic. After four or five days the neurosurgical service determined that they had nothing further to offer him, and since we had been consulted on him medically as family physicians, we were responsible for his care. I worked many weeks and called actually all over this state and in some other areas in the nation trying to find a step-down unit from a hospital. This man was never accepted for any type of care other than hospital care, and if my memory serves me, he survived somewhere between 90 and 120 days in our hospital where all we could do was support him. Ultimately we did lose this patient, but much of the care that he received over the last two to two and one-half months could just as well have been rendered in a skilled care facility, yet we were unable to get him into such a facility.

The following are hospital patients now who with the exception of Mr. W. have been ready for discharge for 10-15 days:

Mr. R. is an 83 year old male, admitted to hospital 9/24/84 with stroke, shingles, organic brain syndrome, diabetic (insulin dependent), Total Care, Medicare and Medicaid. Pre-Admission Evaluation mailed 10/12/84, and the social worker from the nursing home reviewed the PAE prior to sending it to Nashville. The nursing home refused the patient because of confusion; the rationale being they are trying to even out patients requiring total care and being constantly observed with more alert and self-care patients.

Mr. L. is a 79 year old male, admitted to hospital 9/16/84 with organic brain syndrome, dehydration, renal insufficiency. He lives alone; has a son in Memphis, Tennessee, and a step-daughter in Illinois. He has Medicare, but Medicaid eligible when the nursing home accepts him. The PAE was sent on 10/14/84; the nursing home social worker reviewed and visited, then refused admission because of mental status.

Mr. W. is a 74 year old male, admitted to hospital on 8/2/84 with diagnosis of heart disease. He has Medicare and Medicaid eligible. The PAE was sent 10/1/84 with no follow up from the nursing home. Since waiting for an ICF bed, the patient has had another heart attack and now has tube feedings and oxygen. He needs skilled care.

Mrs. Mc is a 63 year old female, admitted to hospital 9/23/84 through the emergency room. Her attending physician was out of town, and the physician covering the emergency room admitted the patient for dehydration and elevated temperature; she had a stroke in 1975. She is Medicare eligible 1977, but not eligible for Medicaid. She has been skilled care since admission to a nursing home one and one-half years ago. Six months ago the family became delinquent in payment; therefore, the nursing home refused to accept the patient back. She has feeding tube and trach. She was eventually placed in another facility only after receiving assistance through the Department of Human Services. She was discharged from the hospital 10/15/84.

I will take your advice and take this matter to the Governor's Task Force and the Adult Protective Services Committee with which I am privileged to work, but it will be some time before I can appear with this committee simply because of the duties that I have here in this clinic.

Enclosed are copies of articles that have recently been published in The Journal of the Tennessee Medical Association. These are for your evaluation as to some of the things that we have been doing here at the grass roots level in serving as advocacy for the elderly. As a physician I do not feel that I can be concerned only with a person's medical problems, but I must be concerned about his/her social and economic problems that bring an impact on the health care status.

Thank you again for allowing me to serve in this small advocacy role for our elder citizens.

Sincerely yours,

Curtis B. Clark, M.D./mc

Curtis B. Clark, M.D.
Assistant Professor of
Family Medicine

CBC:me
Enclosures

TESTIMONY OF MARILYN DAY KRIM

DEAR SENATOR HEINZ:

This testimony states a sequence of events concerning Marguerite o Louisville, Ky., who is now in the H.M. nursing facility in Louisville, Ky.. Mrs. D. is my mother and is now 86 years old.

A problem developed when my mother fell and broke her hip on August 27, 1983. She was livng in Sholom Towers which is a HUD facility in Louisville when the fall took place. It was the second hip fracture in 1-1/2 years. She had surgery and was in Baptist Hospital, East Louisville. After 19 days stay in the hospital I was notified by the social worker in the hospital that my sister and I had to move my mother in two days. I was appointed Power of Attorney while mom was in the hospital and her assets were approximately $24,000. The only income she had was a World War I widows pension of $50.40 per month.

My sister and I investigated nursing homes for mother and due to the short time we had to place her we chose J.M. Nursing Home in Louisville, which is not a Medicaid home. We moved her to J.M. Nursing Home in September 16. 1983. Her recovery wasn't as speedy as we thought. We decided to move her to a Medicaid home as her assets were being exhausted. We had planned to move her after Christmas, 1983. The first of January my husband had a heart attack which postponed moving mother to a Medicaid home until March, 1984.

We checked various homes and as an example the Lutheran home in Louisville said they require 18 months of private pay to get a Medicaid bed. We next went to P.T.V. Nursing Home in Louisville and they require twelve months of private pay for a Medicaid bed. Then we went to H.M. Nursing Home in Louisville and my husband and I talked to the Assistant Administrator, Margaret H.. She said, "Don't expect to put your mother in here for two months and expect Medicaid because it has happened before and the family has to take the loved one in their homes". Ms. H. said to give the home at least three months notice to apply for a Medicaid bed. She also said that "floating Medicaid beds" were available. We moved mother into H.M. Nursing Home in March 1984.

In June, I stopped the social worker, Debbie M., in the hallway and told her mothers funds were going down and she told me to take a mini-vacation with my husband and upon our return she would ask Ms. H. if there was a bed and if given the okay it would take six months to do the paper work. I did not approach her again until July 19 and I asked her to start the process for a Medicaid bed and she told me I had to move mother out as there were no Medicaid beds at Hillcreek at this time. Ms. Morris said there would be a two to three year wait at H.M. Nursing Home. She advised us we may have to move your mother to Indiana or Western Kentucky for a Medicaid bed.

In shock I made an appointment with the Administrator, Shirley R., the next day. Ms. R. said everything Ms. M. said was true with the exception that maybe we could find a Medicaid bed closer to Louisville. I told Ms. R. that another move may kill my mother because she cannot adjust to changes. Ms. R. told my mother could make the change but I can't! I feel I know my mother's mind far better than she does. Mother's physician called Ms. R. at my request to advise her that another move for mom could cause a decline in her health.

That afternoon I came to visit my mother and Cindy V., social worker, asked me to come to her office which I did. She closed the door and sat in front of me and shock her finger in my face many, many times and told me Dr. Q. had called and she wanted me to understand my mother had to pay in order to stay there.

My husband and I went down to the Department of Human Resources to try to get a Medicaid bed for mother and was told that mother had to be assigned to a Medicaid bed before they could start the paper work. The same day we went to the Department there was only one intermediate care bed in Louisville.

I was given a consumer book called "A Place to Live" published by the Kentucky Cabinet for Human Resources. This is a very helpful book that families should have before selecting a home for your loved one. There should be a law that families should be given a copy of this book when selecting a a nursing home before instead of after the fact!

I'm angry and hurt in my cause. I pray something can be done to curtail the pain that I have had to go through to stop the nursing home industry of taking advantage of lay people. Nursing homes (not all of them) take your money and when the money is gone ask you to leave and you are not fully informed of your status when placing your loved ones. We feel as though we have been deceived.

I'm praying for a miracle. I have taken her burial funds to pay the month of September, 1984. For my mom's sake, I hope I can keep her at H.M. Nursing Home.

I have tried in vain to resolve the problem with various pulic officials.

H.M. Nursing Home is owned by a major national nursing home chain.

September 27, 1984

The Honorable Senator John Heinz, Chairman
Senate Special Committee on Aging
Room G33 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Heinz:

My name is Grace McGee. I am eighty-two years old and I live in Tacoma, Washington. I appreciate this opportunity to tell you about my experiences when trying to find a nursing home placement for my brother in Pierce County.

I started taking care of my brother in 1978. My brother is blind and only has the use of his left side. His right leg is amputated above the knee. In 1978, his wife called me from Oklahoma to tell me that she was not able to take care of him. She was two years older than I and she had not been well. If he stayed in Oklahoma he was going to have to go to a nursing home, so I went to pick him up. I brought my brother to Washington and tried to take care of him. The Washington State Chore program gave me some help four hours a day by sending in a personal care worker. The rest of the time I was on duty. I became quite ill, my brother needed additional help and because of the strain of having to care for him I was not able to regain my strength. I

placed my brother in a nursing home for about six months until I could bring him home again and take care of him. On two other occasions I had to place my brother in a nursing home temporarily until I was strong enough to bring him home and take care of him. In the spring of 1984, I became ill again and the doctor said that I had to put my brother in a nursing home because I would never get well if I continued to try to care for him.

My senior case manager was Brian Hake with Good Samaritan Aging Services, which is funded by the Area Agency on Aging. He was trying to help me find a placement for my brother. For several weeks he contacted almost every nursing home in Pierce County and we could not find a home that would admit my brother. Some of them were honestly full. One day in April, Brian called a nursing home in Pierce County and was told that the facility would not take my brother because there were no rooms. They also told him that they were only taking Medicare and private pay patients. The very same day, I called the nursing home, described my brother's condition and asked if there was a room. They asked me how he was going to pay. I told them private pay. I thought I could mortgage my home to pay for it. The nursing home told me to come up and choose a room. Brian Hake was there with me when I made the call.

After the telephone call and the response that the nursing home gave us, Brian and I contacted Jane Beyer. She is a lawyer at Puget Sound Legal Assistance Foundation, who is funded by the Area Agency on Aging and the Legal Services Corporation to provide free legal services to people over age sixty in Pierce County. She immediately sent a letter to the nursing home saying that the Washington State Bureau of Nursing Home Affairs construed the nursing home's Medicaid provider agreement to provide that the only reason a nursing home could reject someone seeking admission was because the nursing home did not have the capacity to provide appropriate care to the individual. Therefore, a nursing home in Washington State could not deny somebody admission based only upon his or her status as a Medicaid recipient. Within two weeks, after several phone calls and meetings with the nursing home, my brother was admitted. The owner of the nursing home called me and gave my brother a choice between two nursing homes. My brother now is receiving adequate care and I finally am able to take better care of myself.

When this occurred Jane Beyer also notified the Washington Bureau of Nursing Home Affairs, the agency responsible for licensing and certifying nursing homes. We got a letter back from the State

Attorney General's Office. They did not take any action against the nursing home. Rather, they suggested that we contact the county prosecutor or the U.S. Attorney. They stated that what happened to my brother appeared to be a violation of federal statutes prohibiting the practice of requiring private payments as a precondition to a Medicaid recipient being admitted to a nursing home. In a conversation with a representative of the Bureau of Nursing Home Affairs, my lawyer was told that the state felt its hands were tied because the only remedy that they had when Medicaid discrimination occurred was decertifing a nursing home from participation in the Medicaid program. The state is reluctant to do this because there is such a shortage of nursing home beds for Medicaid recipients. In another case in Thurston County, Washington, the Attorney General's office wrote back to a lawyer at Puget Sound Legal Assistance Foundation after she had written a letter to the Bureau of Nursing Home Affairs when a client had been denied admission to a nursing home because of his Medicaid status. The letter from the Attorney General's office suggested that the lawyer consider filing a third party beneficiary lawsuit against the nursing home because, again, the state's only real remedy was full decertification and they did not feel that they could take any action.

It would have been helpful to myself and others facing this problem if the federal or state government could have taken some action against the nursing home. Nursing homes should be prohibited from refusing admission to a Medicaid recipient if a bed is available in the facility. If a nursing home violates this provision, it should have to pay a penalty to the government and also should be required to reimburse families that had to pay the private pay rate to a nursing home when their family member was eligible for Medicaid. I also believe that individuals should be able to bring a private cause of action against nursing homes that discriminated against them.

I am happy to see the United States Senate is concerned about people like me who have had such difficulties trying to find a nursing home that will take care of relatives who are Medicaid recipients. I do not want others to have to endure the same problems and pain that I did. Thank you so much for this opportunity to tell you about my experiences.

Sincerely,

Grace McGee

GRACE McGEE
Tacoma, WA

TESTOMONY OF WILLIAM SOHINKI

My name is William Sohinki and I am 61 years of age. I wish to present the following facts concerning my father-in-law, Jacob Bromberg.

In 1977, my father-in-law was becoming increasingly more senile and incontinent. My mother-in-law at this time had to go to the hospital for a gall bladder operation, so we took my father-in-law to our home in Clark to take care of him. As my wife and I both work, we had to hire a nurse to stay with him during the day until one of us came home.

When my mother-in-law got out of the hospital, she also came to our home to recuperate. As my father-in-law's condition worsened, my mother-in-law agreed to put him in a nursing home of her choice. Accordingly, in October 1976, we spoke to officials at the nursing home, asking if he would be acceptable as a Medicaid patient and they assured us that this would be no problem. When a bed was available they would call us.

In February, 1977, they telephoned my wife at work asking that one of us meet with them to discuss a pledge to their building fund. Since my hours were more flexible, I arranged to meet with them. At this meeting, they indicated that his name was at the top of the admission list and if I pledged $10,000 to the building fund he would be admitted. I told them that it was impossible for me to contribute $10,000 as I was still paying off three college educations for my children. They then said that if I didn't pay the $10,000 he would go to the bottom of the admission list.

Several weeks later, I returned to try to bargain with them and they asked for $7500, which I indicated was still too high, and we finally agreed on $5000. Of this, $1000 was to be paid prior to admission and the balance over a four year period. A few weeks later, the first $1000 having been paid, he was admitted.

He passed away on July 2, 1977. Since then we have received numerous letters from collection agencies trying to collect the balance. Had he been treated humanely, as a resident of a Home, we would have made every effort to fulfill our pledge. As this was not so, we feel no obligation to do so.

TESTIMONY OF STEPHANIE WALCHAK

DEAR SENATOR HEINZ:

On October 28, 1982, my father Stanley Bystry, age 88, was being released from the hospital after suffering a stroke, the Doctor and Social Services contacted me about putting him in a Nursing Home, since I would be unable to care for him.

It's difficult finding a Nursing Home with a bed available. I tried for 3 days. Finally, I located N.N. Nursing Home in Sterling Heights, MI.

Frantic, I signed an agreement stating I would provide for his care and I had to pay $1,310 that day. The doctors predicted my Dad wouldn't last too long and since I loved him and wanted the best care for him, I thought, well maybe I could swing it for a short time he had left. He had Blue Cross which covers 6 weeks of Nursing care. But my Dad lingered and the monthly expenses were mounting and bills were coming in, I panicked. My daughter visited me and called "Citizens for Better Care", the Michigan Ombudsman organization. I did apply for Medicaid on October 28 and was approved retroactive to October 1, but when I took the form to the Nursing Home office, I was told I was obligated to pay since I signed the contract.

Citizens for Better Care came to my rescue. A man from Lansing contacted the nursing home administrator, who called me up and made an appointment with me. They then informed me that my Dad had a pension because of his Blue Cross and I informed them that my Dad hadn't worked since 1946, and I was paying for his Blue Cross out of my retirement pension. Mr. Gaynier then informed me if I paid $2100.90 in May, my Dad could go on Medicaid effective July 1, 1983, he died July 31, 1983.

I paid a total of $3,033 out of my personal funds and my own retirement pension after my father became Medicaid eligible.

Appendix 10

TESTIMONY OF FRAN SUTCLIFFE, DIRECTOR
Nursing Home Hotline Patrol
St. Petersburg, Florida

DEAR SENATOR HEINZ:

My name is Fran Sutcliffe. For the past ten years, I have been assisting families in finding suitable nursing home placements for members of their family. This service is free and my efforts are completely voluntary.

It disturbs me to continue to receive reports from families that nursing homes certified under the Medicaid program are demanding six months to a year private pay before accepting a patient under the Medicaid program.

Private pay demands are no longer written into contracts as they were a few years ago. The industry has been convinced that this is an illegal practice, so contracts have been rewritten removing that demand. Unfortunately this does not prevent oral demands and oral agreements which cannot be documented. Many times I have asked families to give me a written statement supporting the oral request and agreement on their part for a private pay period. Because of the extreme nursing home bed shortage, due to the Certificate of Need system, families are afraid they will be black-balled by all nursing homes. They are simply afraid to give such information in writing or let it be known they have complained to anyone.

When the Medicaid program is reviewed I sincerely hope some adjustments can be made in federal legislation which will protect these very vulnerable families from the blackmail they must now tolerate in order to secure nursing home care.

BEST COPY AVAILABLE

Milwaukee Sentinel April 14, 1984 Page 1.

Nursing-home chain segregating patients on Medicaid

By Mary Zahn

A Wisconsin-based nursing home corporation has begun segregating residents whose bills are being paid by the government-financed Medicaid program.

The segregation, which involves putting private-pay residents in newly remodeled areas and keeping Medicaid residents in less attractive rooms, has been implemented in three Milwaukee-area nursing homes.

Calling the situation "cruel and unacceptable," George Pennacchio, executive director of the State Board on Aging and Long Term Care, said the agency would "suggest that legislation get prepared to stop this."

"Can you imagine what the psychological effect is on an elderly person who runs out of money and is told they must move to the welfare wing of the nursing home?" Pennacchio said.

A reporter who toured the homes — River Hills East, 1301 E. Franklin Pl.; River Hills West, in Pewaukee; and Park Manor, 1524 E. Park Pl. — was told that when residents could no longer pay privately for their care, they were moved to the wing set aside for Medicaid recipients.

The private-pay rooms have been newly remodeled and look like new hotel rooms, with expensive-looking draperies in colors coordinated with the newly papered walls, while chenille bedspreads round off the look.

The Medicaid rooms are more stark, with dark blue lightweight bedspreads and cotton window curtains, many of them in a bold floral pattern.

The walls in most of these rooms were painted an eggshell color, with the exception of one home, where one wall in some of the Medicaid rooms was painted a bright blue or orange. All the rooms were clean and neat.

In two of the homes, River Hills East and River Hills West, nursing home officials said separate dining rooms with special menus for private-pay patients were being planned.

The reporter was also told that other common areas of the homes, such as lounges and patios, were open to all residents regardless of how their bills were paid.

Allen I. Samson, executive vice president of American Medical Services, which owns the three homes, said the segregation was a marketing experiment. By offering more amenities and more rooms in one section of the home, he said his corporation hoped to attract more private-pay people.

The firm owns 16 nursing homes nationwide, 7 of which are in Wisconsin.

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Samson said that because Medicaid reimbursement rates had not kept up with inflation, it was important for nursing homes to attract more people who could pay the higher rates in order to survive financially. He said the competition for such people was fierce.

"If our program is successful and we can increase the number of private-pay patients in a nursing home, we can accomplish all kinds of things that are positive for everyone," Samson said.

"We can have more staff. The more private-pay patients a nursing home has, the more nursing hours it can have. And those (hours) would not be distributed according to how much money you have, but according to how much care you need," he said.

Samson said if he was able to attract more private-pay residents by offering these nicer accommodations, he might expand the idea to other nursing homes.

He said the staffing budgets for nursing services were the same for the private-pay and Medicaid wings of the homes.

"I don't believe there is any stigma attached to being in any part of any of our nursing homes," Samson said.

Pennacchio said that, nonetheless, nursing homes had a mix of private-pay and Medicaid patients, with both types of patients getting the same kind of rooms and services despite differences in payment levels.

He said that about seven years ago, expanded their life savings within two years of entering a nursing home and, by necessity, transferred to the Medicaid program, "everything equalizes out in the end."

However, he said, a recent Federal Court ruling had the nursing home industry on edge.

That ruling, he said, "could a Milwaukee state law making it illegal for nursing homes there to charge Medicaid-only patients more than Medicaid reimbursement rates" for the same services.

Milwaukee officials said that court ruling was being appealed and might go to the US Supreme Court. The officials said that as a result, nursing homes in Milwaukee had begun offering special services, such as cut flowers, extra outings and special birthday parties, to both Medicaid and private-pay patients for additional fees.

"Our stand is taking the position that we will not allow nursing homes to be segregating by type of payment under any circumstances," said Gail Gibson, a Milwaukee assistant attorney general.

Pennacchio said that to be eligible for Medicaid, a person could have only $1,500 in savings. $1,500 in a pre-need life insurance policy and $1,500 in an irrevocable burial trust fund.

He noted that most nursing homes in Wisconsin were either required, or give priority to, a person going into a nursing home who could pay privately for their care for six months to a year before shifting to the Medicaid program.

"The potential for discrimination on the quality of nursing care exists with this type of (segregated) system," Pennacchio said.

Some of the amenities listed for private-pay patients include arrangements for admission to shows, theaters and other events, special service on the facility's videotape player, selective menus, vintage table wine for special occasions, a free rental designer wristband for "dignified patient identification," fluffy face and bath towels, and a free massage and back rub on request.

Park Manor also offers a "portrait of resident upon request of resident, or family, within first year at Park Manor."

Samson said most daily recreation activities were open to both private-pay and Medicaid residents.

He said he had received positive reactions from residents living in the three nursing homes and knew of no cases in which patients were transferred by a room change.

"The assumption that we are offering are similar to luxuries," Samson said. "The absence of them isn't deprivation. The absence of them is simply non-luxury. For example, fluffy towels and a bedspread wrinkled."

He said the situation in these homes was similar to anything else in life. Those who could pay for the luxuries received them, he said, and those who could not, did not.

"In the outside world, we would look at that simply in terms of economic condition" Samson said.

"The fact is, that is that constant, the word 'fair' doesn't come up. To come at me in the health care situation and to say, 'Is it fair you get this when you could afford it and now must move because you can't afford to do this?' well, the question isn't fair."

Shirley Ellis, director of ombudsman services for the State Board on Aging and Long Term Care, said segregating residents on the basis of source of pay was morally wrong.

"Many of these people have paid taxes, have paid their dues and have never required, or asked for, Medicaid or welfare on the outside," Ellis said.

"Now they are forced into something in their illness that they would have never done otherwise. Just think of $40,000 gone in two years, and think about having someone say, 'And now that you're welfare, you have to move to the welfare wing,'" she said.

Mimi Chernov, director of the older adult living alternatives program for the Interfaith Program for the Elderly, said she would alert people to nursing homes segregating residents based on "income."

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MILWAUKEE SENTINEL

Friday morning, April 20, 1984

Reivitz criticizes homes' division of patients over aid

By Mary Zabo

Separating nursing home residents on the basis of whether their care is financed by Medicaid or private money is unacceptable and disturbing, the secretary of the State Department of Health and Social Services said Thursday.

A Milwaukee Sentinel article has revealed that certain health care providers in Wisconsin are considering changes which could lead to altering our traditional principles of uniform quality health care for all," Linda Reivitz said in a written statement.

I am disturbed at any age that serious consideration is being given to a system that encourages the segregation of individuals — especially the elderly — by economic status. That is not acceptable in an acute medical care setting, or in nursing homes.

Health care and long-term care are important issues. Problems in these areas often have expensive solutions. We will not choose those solutions which place elderly, or any other persons in Wisconsin, in second-ly or otherwise inferior or degrading positions, she said.

The Sentinel reported April 14 that a Wauwatosa-based nursing home corporation had begun segregating residents whose bills were being paid by the Medicaid program, which is financed by the federal and state governments.

The segregation, which involves putting private-pay residents in newly remodeled areas and housing Medicaid residents in less luxurious rooms, has been implemented in three Milwaukee area nursing homes. In two of the homes, separate

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Reivitz raps nursing homes for segregation of patients

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dining rooms with special menus for private-pay residents were being planned.

A reporter who toured the homes — River Hills East, 1301 N. Franklin Pl., River Hills West, Milwaukee, and Park Manor, 1920 E. Park Pl. — was told that when residents no longer could pay privately for their care, they were moved to the wing set aside for Medicaid recipients.

Joseph Sciskowicz, a spokesman for Reivitz's department, said Reivitz had directed her staff to research the Milwaukee area situation and to get additional information on a federal court ruling in Minnesota.

That ruling upheld a Minnesota law barring nursing homes there from charging private-pay patients more than Medicaid reimbursement rates for the same services.

Because of that ruling, Minnesota officials said, nursing homes in Minnesota have begun offering special services, such as cut flowers, extra outings and special birthday parties to both Medicaid and private-pay patients for additional fees.

The ruling is being appealed by the nursing home industry.

After Reivitz receives reports by two state committees looking into problems of the nursing home industry, she will decide whether a regulatory remedy is needed to stop the separation of nursing home residents based on finances, Sciskowicz said. Those reports are expected by summer, he said.

One of those concerns, Sciskowicz said, is the nursing home industry's position that the Medicaid reimbursement rate does not cover the cost of patient care.

Officials said most Wisconsin nursing homes had a mixture of private-pay and Medicaid patients, with both getting the same kind of rooms and services despite differences in payment levels. Officials said most people expended their life savings within two years of entering a nursing home and, by necessity, transferred to the Medicaid program.

To be eligible for Medicaid, a person may have only $1,500 in savings, $1,500 in a paid-up life insurance policy and $1,500 in an irrevocable burial trust fund. Most nursing homes in Wisconsin now require, or give priority to, people going into a nursing home who can pay privately for their care for six months to a year before shifting to the Medicaid program.

Allen L. Samson, executive vice president of A'harson Medical Services, which owns the three nursing homes looked at by a reporter, said the segregation was a marketing experiment. By offering more amenities and nicer rooms in one section of the home, he said, his corporation hoped to attract more private-pay residents.

Because Medicaid reimbursement rates have not kept up with inflation, nursing homes need to attract more people who can pay the higher rates if the homes are to survive financially, Samson said.

If his program succeeds, Samson said, he might expand the idea to other nursing homes. The firm owns 15 nursing homes nationwide, 7 in Wisconsin.

He said staffing budgets for nursing services were the same for the private-pay and Medicaid wings of the homes and he did not believe that any stigma was attached to being in any part of his nursing homes.

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